

4204

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>4629 Henderson Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Augustus</u> Middle <u>John</u> Last <u>ADAMS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-20-83</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy (Retired)</u>			
11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Lorenzo Adams</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Fagan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		(If yes, give war or dates of service) <u>WW-I & II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>(Daughter) Mrs. Alice C. Swanick (Same As #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopulmonary Suppurative disease</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Organism not determined.</u> <u>Chronic bronchitis and distal airway emphysema + 44 years.</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>10</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>15 April</u> , 19 <u>57</u> , to <u>16 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>15 April</u> , 19 <u>57</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Harold I. Passes</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>4-17-57</u>							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) <u>Harold I. Passes, LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL HOME <u>Fitzgerald Funeral Home</u>				24a. REC'D BY REGISTRAR DATE <u>4-17-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Parrell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF DEATH

BUREAU V. 3

APR 22 1957

RECEIVED

4167

CERTIFICATE OF DEATH

Reg. Dist. No.

273

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>11606 Ashley Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Pauline</u> Middle <u>—</u> Last <u>Allen</u>		4. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-80</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louie</u> XXXX		14. MOTHER'S MAIDEN NAME <u>Unknown</u> <u>Sophie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Washington Sanitarium & Hospital Recd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RUPTURED ABDOMINAL ANEURYSM</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PARTIAL SMALL INTESTINAL OBSTRUCTION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-23</u> , 19 <u>57</u> , to <u>4-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-25</u> , 19 <u>57</u> , and that death occurred at <u>6:25</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. C. Carrick</u>		ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd. Rockville Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. M. C. Carrick</u>		DATE SIGNED <u>4/25/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/29/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Elkridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		24a. REC'D BY REGISTRAR <u>J. Stansbury</u>	
ADDRESS <u>6411 Windsor Mill Rd.</u>		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 29 1957

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH—BAYLOR, 10

BUREAU V. S.

APR 29 1957

RECEIVED

4205

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5810 Georgia Ave.</u>				d. STREET ADDRESS <u>18810 Georgia Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED <u>JAMES</u> First <u>HOWARD</u> Middle <u>ARMSTRONG</u> Last				4. DATE OF DEATH Month <u>APRIL</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>8/3/88</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>WILLIAM A. ARMSTRONG</u>				14. MOTHER'S MAIDEN NAME <u>KATE SNYDER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>225-22-8693</u>		17. INFORMANT Address <u>Mrs. Gladys L. Armstrong, 11, 109 Midvale Rd. Kensington, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis, Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>2 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March 28, 1957</u> , to <u>April 1, 1957</u> , that I last saw the deceased alive on <u>April 1, 1957</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>James A. Roberts</u> M.D. <u>5927 Georgia Ave. Silver Spring Md 4/1/57</u>							
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clarence B. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>4/8/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Francis J. Miller</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ILLINOIS STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

BUREAU V. S.

APR 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
42:6
CERTIFICATE OF DEATH

04175
214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 12 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING		d. STREET ADDRESS 9516 THORNHILL ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9516 THORNHILL ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JESSIE Middle PRATT Last BARNUM		4. DATE OF DEATH Month APRIL Day 29 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 22, 1858
9. AGE (In years last birthday) 98 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER - OWN HOME		10b. KIND OF BUSINESS OR INDUSTRY ILLINOIS	
11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN PRATT		14. MOTHER'S MAIDEN NAME CHARITY CHURCH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. John F. McClelland, Address 9516 Thornhill Road Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 months years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured Hips - July 1956		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fall in home		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. July 1956 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Silver Spring Montgomery Md.	
21. I certify that I attended the deceased from June, 1951 , to April 29, 1957 , that I last saw the deceased alive on April 22, 1957 , and that death occurred at 1 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8248 Georgian Ave. DATE SIGNED 4/29/57			
ACTUAL SIGNATURE Merrill M. Cross M.D.		M.D. 8248 Georgian Ave.	
PHYSICIAN'S NAME (Type) MERRILL M. CROSS M.D. Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 5/3/57		22b. DATE THEREOF 5/3/57	
22c. NAME OF CEMETERY OR CREMATORY OAKWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) TROY, NEW YORK	
23. FUNERAL DIRECTOR'S SIGNATURE Wesley E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR 34/57		DATE 34/57	
24b. REGISTRAR'S SIGNATURE James Potter			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. 8

MAY 7 1957

RECEIVED

4163 CERTIFICATE OF DEATH

Reg. Dist. No. 2V3

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ITTakoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp</u>				d. STREET ADDRESS <u>17500 Wildwood Dr</u>			
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Isaac</u> Last <u>Bassford</u>				4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/15/69</u>		9. AGE (In years last birthday) yrs. <u>87</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Bassford</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Wrenn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chemia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis of kidneys</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>many years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral atrophy due to arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 1957, to <u>April 8</u> , 1957, that I last saw the deceased alive on <u>April 8, 1957</u> , 19____, and that death occurred at <u>10:20 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest A. Sarao</u>		M.D. <u>1006 New Hampshire Ave</u>		ADDRESS (Street, city or town, state) <u>TAKOMA PARK, MD.</u>		DATE SIGNED <u>4/8/57</u>	
PHYSICIAN'S NAME (Type) <u>ERNEST A. SARAO, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 10, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beallsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW</u>				ADDRESS <u>254 Carroll St NW</u>		24a. REC'D BY REGISTRAR DATE <u>4/10/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Nelson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

APR 12 1957

RECEIVED

4169

CERTIFICATE OF DEATH

01177

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
c. LENGTH OF STAY IN 1b <u>13 hrs.</u>				d. STREET ADDRESS <u>5403 Queens Chapel Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marjorie Verline Bata</u>				4. DATE OF DEATH <u>April 22 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-21-21</u>	
9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HSWg OWN/NOE</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry R House</u>				14. MOTHER'S M maiden name <u>Ruth Phipps</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Post partum hemorrhage</u> DUE TO <u>Placenta accreta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Placenta accreta</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>about 6 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Massive intraperitoneal hemorrhage following hysterectomy for placenta accreta</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 14, 1956</u> , to <u>April 22, 1957</u> , that I last saw the deceased alive on <u>April 22, 1957</u> , and that death occurred at <u>7:37 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Emma Hughes</u> M.D. <u>TAKOMA PARK, MD.</u>				<u>APRIL 22, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Emma Hughes</u>				<u>WASHINGTON SANITARIUM, TAK. PK. MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>APR 23 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HYATTSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Jones</u> ADDRESS <u>254 Carroll St NW.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>4-2-57</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04178

4207

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd's				c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd's	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Elizabeth Last Beall				4. DATE OF DEATH Month April Day 2 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 24, 1869	
9. AGE (in years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Montg. Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Hager				14. MOTHER'S MAIDEN NAME Sarah Ellen Gue			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs W. Melvin Carlin, Boyds, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 years				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 9. Month, 19 Day, 19 Year p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10, 1946 to April 2, 1957 , that I last saw the deceased alive on March 31, 1957 , and that death occurred at 2:00 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr				ADDRESS (Street, city or town, state) Damascus, Md.		DATE SIGNED 4/3/57	
PHYSICIAN'S NAME (Type) James P. Kerr							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 4, 1957		22c. NAME OF CEMETERY OR CREMATORY Salem		22d. LOCATION (City, town, or county) (State) Cedar Grove, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE April 4/57	
				24b. REGISTRAR'S SIGNATURE Della V. Burdett			

BUREAU V. S.

APR 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4208 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04179

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>John William Beall</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>John William Beall</u> First Middle Last				4. DATE OF DEATH Month <u>Apr</u> Day <u>21</u> Year <u>1957</u>																			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-19-1881</u>		9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Elmer Beall</u>				14. MOTHER'S MAIDEN NAME <u>Ida Fyles</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>J. M. Conner - Rockville md</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to</u> DUE TO (c) <u>due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u> <u>sudden</u>																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>Frank J. Broschelt</u> M.D.								CHIEF MEDICAL EXAMINER <input type="checkbox"/>															
EXAMINER'S NAME (Type) <u>FRANK J. Broschelt</u>								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>															
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								DATE SIGNED <u>4-21-57</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/24/57</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>				22d. LOCATION (City, town, or county) (State) <u>Beallsville md</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u>								ADDRESS <u>Barnesville, Md</u>															
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <u>Charles W. Elgin</u>				DATE <u>4/22/57</u>															

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

BUREAU V. S.

APR 24 1957

RECEIVED

4209

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE M. ryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
c. LENGTH OF STAY IN 1b 16 days				d. STREET ADDRESS 3909 Washington St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Gibson Last Beddie				4. DATE OF DEATH Month April Day 29 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1904	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 29 Days 19 Hours 57	IF UNDER 24 HRS. M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer (Composer)		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Beddie				14. MOTHER'S MAIDEN NAME Annetta Swanson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 474-09-8930		17. INFORMANT Mrs. Elma Beddie Address Kensington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CACHEXIA OF MALIGNANCY X DUE TO CARCINOMA OF STOMACH WITH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. METASTASIS. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 19 56 to April 29 19 57 that I last saw the deceased alive on April 28 19 57 and that death occurred at 2:00 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE George Sharpe MD.		M.D. George Sharpe		ADDRESS (Street, city or town, state) Kensington, Md.		DATE SIGNED 4/29/57	
PHYSICIAN'S NAME (Type) George Sharpe							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/1/57		22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Park Cemetery, Elkton, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Walter C. Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 5-2-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 21

MAY 3 1957

RECEIVED

4210 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Crestview	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Crestview	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4710 Bayard Blvd.		STREET ADDRESS (If rural give location) 4710 Bayard Blvd.	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Ernest (Middle) August (Last) Behrens		(Month) April (Day) 21 , (Year) 1957	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 1/25/1889
9. AGE last birthday 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles . Behrens		14. MOTHER'S MAIDEN NAME --	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS Elsie D. Behrens-4710 Bayard Blvd. Crestview, Md.			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Acute coronary thrombosis (myocardial infarction)		INTERVAL BETWEEN ONSET AND DEATH minutes	
ANTECEDENT CAUSE(S) DUE TO (B) Generalized arteriosclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) with coronary sclerosis		1 1/2 years	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. He had an acute coronary thrombosis at the time first and I have treated him since then.		I saw him	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) I Talked to the coroner about this case and			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not white <input type="checkbox"/> he directed that I sign the certificate			
22. I hereby certify that I attended the deceased from Dec. 19, 1955 , to Feb. 27, 1957 , that I last saw the deceased alive on Feb. 27, 1957 , and that death occurred at 6:30 AM , from the causes and on the date stated above.			
SIGNATURE C. P. RYLAND		DATE SIGNED 4400- 49th St. N.W. Washington, D.C. 4-21-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/24/57	
NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		LOCATION (City, town, or county) (State) Prince Georges County, Md	
24. REC'D BY REGISTRAR DR 24 1957		25. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hinos Co. 2901 14th St. NW Washington, D.C.	

INSTRUCTIONS

1. ANYTHING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

BUREAU V. E.

APR 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

04152
2132

4170

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14th Ave Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>			
c. LENGTH OF STAY IN 1b <u>23 days</u>				d. STREET ADDRESS <u>2228 N. Dakota Ave. N.W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Gen. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>Mary</u> Middle <u>Emily</u> Last <u>Bell</u>		4. DATE OF DEATH		Month <u>April</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11, 1881</u>	9. AGE (in years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hsueh</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John W. Ferguson</u>			
14. MOTHER'S MAIDEN NAME <u>Charles L. Zirkle</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Pts daughter - same as above</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Posterior Myocardial Infarction</u> <u>4.0.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>3/23</u> , 19 <u>57</u> , to <u>4/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/14</u> , 19 <u>57</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dean H. Harding</u> M.D.				ADDRESS (Street, city or town, state) <u>113 Carroll St NW Wash, D.C.</u> DATE SIGNED <u>4/14/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>Raymond H. Brown</u>		<u>1111 1st St NW</u>		<u>APR 19 1957</u>		<u>J. H. Drell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4211

CERTIFICATE OF DEATH

04183

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		e. STREET ADDRESS Rt. #2, Good Hope Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Alice Bellows		4. DATE OF DEATH Month Day Year April 5 19 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31/60
9. AGE (In years last birthday) 97 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY. USA	
13. FATHER'S NAME Unknown Adams		14. MOTHER'S MAIDEN NAME Henrietta Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage X DUE TO Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 7 days Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/28 , 19 57 , to 4/5 , 19 57 , that I last saw the deceased alive on 4/4 , 19 57 , and that death occurred at 6:00 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. W. Bird		M.D. Sandy Spring Md.	
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.		DATE SIGNED Sandy Spring Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/8/57	22c. NAME OF CEMETERY OR CREMATORY Good Hope,	22d. LOCATION (City, town, or county) (State) Colesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surda		ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR DATE 1057
		24b. REGISTRAR'S SIGNATURE Gertude Lowrey	

RECEIVED

APR 9 1957

RECEIVED

04184

4212

CERTIFICATE OF DEATH

Reg. Dist. No. 266

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. STREET ADDRESS 10002 Summit Avenue	
3. NAME OF DECEASED (Type or print) First William Middle W. Last Bennett		4. DATE OF DEATH Month April Day 20 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/86
9. AGE (in years last birthday) 71 yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months 1 Days 12 Hours 12 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-Salesman		10b. KIND OF BUSINESS OR INDUSTRY C & P Tel.Co.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Gordan Bennett		14. MOTHER'S MAIDEN NAME Mary Elizabeth Honggi	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-01-1996	
17. INFORMANT Olive Bennett		Address -- above Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO (c) 1 yr		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 11, 1957 to April 20, 1957 that I last saw the deceased alive on April 20, 1957 and that death occurred at 10:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Sidney C Cousins M.D. 3921 Langdon St. N.W. #225		PHYSICIAN'S NAME (Type) SIDNEY C COUSINS Wash DC	
22a. BURIAL (CREMATION, REMOVAL) (Specify) Burial	22b. DATE THEREOF 4/23/57	22c. NAME OF CEMETERY OR CREMATORY Nat. Mem. Park. Cem.	22d. LOCATION (City, town, or county) (State) Falls Church, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey,		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR 4-22-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU Y. B.

8 24 1957

CEIVED

4213

CERTIFICATE OF DEATH

04185

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>J.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>Key West 47</u>			
3. NAME OF DECEASED (Type or print) First <u>Kim</u> Middle <u>Warner</u> Last <u>BERGENHOLTZ</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 December 1955</u>	9. AGE (In years last birthday) <u>1</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Raymond Warner Bergenholtz</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Ann Christiana (Same As #2)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>(Mother) Mrs. Josephine A. Bergenholtz</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>NEUROBLASTOMA</u> <u>193X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>17 April</u> 19 <u>57</u> , to <u>19 April</u> 19 <u>57</u> , that I last saw the deceased alive on <u>19 April 1957</u> , 19 <u>57</u> , and that death occurred at <u>4:20A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>4-20-57</u> SIGNATURE <u>Daniel Shuptar</u> M.D. PHYSICIAN'S NAME (Type) <u>DANIEL SHUPTAR, LT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-23-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>1007 Wisconsin Ave., Bethesda, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>4-20-57</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04186

Reg. Dist. No. 214

4214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.H</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>5217-ANDOVER Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Harrison Bishop</u>				4. DATE OF DEATH Month Day Year <u>4-10-57</u> 19 <u>57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>WIDOWED</u> <u>DIVORCED</u> <u>JAN-11-1900</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Attorney</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>			
13. FATHER'S NAME <u>HARRISON SCOTT Bishop</u>				14. MOTHER'S MAIDEN NAME <u>Rose McGivern</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Int. col. Air Force</u>		16. SOCIAL SECURITY NO. <u>Int. col. Air Force</u>		17. INFORMANT <u>MRS. Viola Bishop - 5217 Andover Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis Coronary Arteries</u> DUE TO (c) _____ </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-10-57</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			
22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>		24a. REC'D BY REGISTRAR <u>4-11-57</u>		24b. REGISTRAR'S SIGNATURE <u>Benjamin Thompson</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 15 1957

RECEIVED

4215

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5202 Newport Ave.</u>		d. STREET ADDRESS <u>5202 Newport Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Christine</u> Middle <u>BORREGARD</u> Last <u>BORREGARD</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 4-1861</u>
9. AGE (In years last birthday) <u>95</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Knudsen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>R. C. Borregard-5202 Newport Ave.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Serology</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH. <u>Undetermined many years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Dec 14</u> , 19 <u>56</u> , to <u>April 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 11</u> , 19 <u>57</u> , and that death occurred at <u>10:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arnon H. Traum</u>		DATE SIGNED <u>Apr 18 1957</u>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
<u>Lee Funeral Home 300 4th NE</u>		<u>APR 23 1957</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 23 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04188

216

4216

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 3813 Florence Drive			
3. NAME OF DECEASED (Type or print) First Maude Middle Zirkle Last Bowie				4. DATE OF DEATH Month April Day 27 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Claiborne Joseph Zirkle				12. CITIZEN OF WHAT COUNTRY? U.S.			
14. MOTHER'S MAIDEN NAME Frances Elizabeth Hite							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Wm. Z. Bowie Address 6455 Barnaby St., N.W., Wash. D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY THROMBOSIS DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIO SCLEROSIS							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour 19 Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 27 April 1957 to 2 April 1957 , that I last saw the deceased alive on 27 April 1957 , and that death occurred at 1:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur Richmond M.D.				ADDRESS (Street, city or town, state) 5522 M Street N.W. DATE SIGNED 28 April 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		April 30, 1957		Rock Creek Cemetery		Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Chamberlaine Co. ADDRESS 1400 Chapin St. N.W.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Bessie Thompson	
				DATE APR 30 1957			

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 30 1957
BUREAU V. S.

04189

4217

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>District of Columbia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>211 "E" St., N.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Shields</u> Middle <u>King</u> Last <u>BOWLES</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 August 1890</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard (Civil Service)</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Hal Bowles</u>		14. MOTHER'S MAIDEN NAME <u>Florence Brannham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 7-6-17 to 5-9-19</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>(Wife) Mrs. Mabel Hunter Bowles (Same as #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>197X</u> DUE TO <u>Assema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinoma invading and occluding</u> DUE TO <u>inferior vena cava and renal veins.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>3 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>While at work</u> <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. (City or town) <u>Washington</u>		20f. (County) (State)	
21. I certify that I attended the deceased from <u>11 March</u> , 19 <u>57</u> , to <u>29 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>29 April</u> , 19 <u>57</u> , and that death occurred at <u>1:16 P.M.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>4-30-57</u>			
ACTUAL SIGNATURE <u>J. T. Horgan</u>		M. D. <u>U.S. Naval Hospital, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. T. Horgan, LT, MC, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-3-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Lee & Son Co.</u>		24a. REC'D BY REGISTRAR <u>DATE 4-30-57</u>	
24b. REGISTRAR'S SIGNATURE <u>James E. Carter</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 1 1957

RECEIVED

4218

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b 6 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3214 Fayette Road				d STREET ADDRESS 3214 Fayette Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First IDA Middle E. Last BOYD				4. DATE OF DEATH Month APRIL Day 24 Year 19 57			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/86	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File Clerk		10b. KIND OF BUSINESS OR INDUSTRY Publishing Co.		11. BIRTHPLACE (State or foreign country) New York City, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FREDERICK BREY				14. MOTHER'S MAIDEN NAME ADOLPHINE GIESSEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-20-5811A		17. INFORMANT Address Mrs. Eileen Pfreundschuh, 3214 Fayette Road Kensington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism (acute) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombophlebitis of lower leg DUE TO Carcinoma of Breast - Radical Resection (c) Adenoma Thyroid Resected 2-6-57 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2-15-1957 Carcinoma of Breast - Radical Resection							INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs 1 week
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954 , 19____, to 4/23 , 19 57 , that I last saw the deceased alive on 4/23/57 , 19____, and that death occurred at 2A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kensington, Md. DATE SIGNED 4/24/57							
ACTUAL SIGNATURE Samuel Allen M.D.		PHYSICIAN'S NAME (Type) Samuel Allen		ADDRESS Kensington, Md.			
22a. BURIAL, CREMATION, or other disposal (Specify) TRANS. & BURIAL		22b. DATE THEREOF 4/27/57		22c. NAME OF CEMETERY OR CREMATORY FRESH POND CEMETERY		22d. LOCATION (City, town, or county) (State) MIDDLE VILLAGE, NEW YORK	
23. FUNERAL DIRECTOR'S SIGNATURE Walter B. Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 4-25-57		24b. REGISTRAR'S SIGNATURE James [illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Pages 1, 2, and 3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4219

CERTIFICATE OF DEATH

041914

Reg. Dist. No. 214

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8633 - 11th AVENUE				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
f. STREET ADDRESS 8633 - 11th AVENUE				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BARBARA ELALIEU BRANDE				4. DATE OF DEATH APRIL 15 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 21, 1936	
9. AGE (In years last birthday) 21 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY -- FEDERAL				10b. KIND OF BUSINESS OR INDUSTRY RESERVE BOARD			
11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME WILLIAM REID BRANDE				14. MOTHER'S MAIDEN NAME ORETA AUSTIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 577-46-2223			
17. INFORMANT MRS. WILLIAM REID BRANDE, 8633 - 11th AVE., SILVER SPRING				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGENITAL HEART DUE TO ABNORMALITY - STRESS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE PAROXYSMAL TACHYCARDIA (c) ACUTE PAROXYSMAL TACHYCARDIA							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 1956 to April 15, 1957 , that I last saw the deceased alive on April 15, 1957 , and that death occurred at 7:00 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas F. Quinn M.D.				DATE SIGNED 501-8 Southampton Drive			
PHYSICIAN'S NAME (Type) THOMAS F. QUINN M.D.				ADDRESS (Street, city or town, state) SILVER SPRING, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/17/57		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR 4/18/57		24b. REGISTRAR'S SIGNATURE Frances J. Jetter	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04192

4220

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>		c. LENGTH OF STAY IN 1b <u>10 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>E.</u> Last <u>Burdette</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Howard Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles F. Layton</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Warfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Roger F. Burdette, College Park, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>0</u> DUE TO (c) <u>0</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 15, 1954</u> to <u>April 6, 1957</u> , that I last saw the deceased alive on <u>April 6, 1957</u> , and that death occurred at <u>2:15 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Damascus, Md.</u> SIGNATURE <u>James P. Kerr</u> M.D. <u>James P. Kerr</u> DATE SIGNED <u>4/8/57</u> PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 9, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Browningsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Molesworth</u>		24a. REC'D BY REGISTRAR DATE <u>Apr. 9/57</u>	
ADDRESS <u>Damascus, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Wella W. Burdette</u>	

RECEIVED

NOV 10 1901

RECEIVED

4221

CERTIFICATE OF DEATH

Reg. Dist. No.

04193214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11,300 GALT AVENUE		d. STREET ADDRESS 11,300 GALT AVENUE	
3. NAME OF DECEASED (Type or print) First FRANK Middle CALIGURI Last CALIGURI		4. DATE OF DEATH Month APRIL Day 14 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 21, 1883
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR: Months 73 Days 73 Hours 73 Min 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARDNER - U. S. Capital		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANTHONY CALIGURI		14. MOTHER'S MAIDEN NAME JENNIE CALIGURI	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 579-07-7144	
17. INFORMANT Mr. Albert Fiorentino, 11,300 Galt Ave.		Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis, Generalized DUE TO (c) 1 day years		INTERVAL BETWEEN ONSET AND DEATH 1 day years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1957 to April 14, 1957 that I last saw the deceased alive on April 14, 1957 , and that death occurred at 10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave DATE SIGNED 4/17/57			
ACTUAL SIGNATURE John J. Curry NAME (Type) JOHN J. CURRY			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/18/57	22c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey		ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR DATE 4/18/57
		24b. REGISTRAR'S SIGNATURE Frances Potter	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 22 1957

BUREAU V. E.

4222

CERTIFICATE OF DEATH

Reg. Dist. No.

04194

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>11 Armor Green S.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Theresa</u> Middle <u>Ann</u> Last <u>CAPECI</u>				4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 April 1957</u>		9. AGE (In years last birthday) <u>3</u> yrs	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.	IF UNDER 24 HRS Hours <u>3</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Lee Capeci</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Frances Boerner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>(Father) Robert L. Capeci (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGENITAL ATELECTASIS</u> <u>162.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>72 Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 April</u> , 19 <u>57</u> , to <u>23 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>23 April</u> , 19 <u>57</u> , and that death occurred at <u>3:00 A.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>4-23-57</u>							
ACTUAL SIGNATURE <u>Daniel Shustar</u>		M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>					
PHYSICIAN'S NAME (Type) <u>Daniel Shustar, LT, MC, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>26 Apr. 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Wampler</u>				24a. REC'D BY REGISTRAR <u>DATE 4-23-57</u>		24b. REGISTRAR'S SIGNATURE <u>Brayton Parrelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2151242XV2

RECEIVED

APR 24 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4223 CERTIFICATE OF DEATH

04195
279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b 8 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2200 DENNIS AVENUE				d. STREET ADDRESS 2200 DENNIS AVENUE			
3. NAME OF DECEASED (Type or print) First NANNIE Middle MAE Last CARMER				4. DATE OF DEATH Month APRIL Day 3 Year 19 57			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/26/74		9. AGE (In years less birthday) yrs. 82	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown LOCKHART				14. MOTHER'S MAIDEN NAME CATH-ERINE BOOTH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Tyree B. Cunningham, 2200 Dennis Avenue Silver Spring, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2212 DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 1 Day (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 1 Day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1952 to April 3 1957 that I last saw the deceased alive on April 3 1957 , and that death occurred at 8:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Silver Spring, Md DATE SIGNED 4/4/57							
ACTUAL SIGNATURE John J. Curry M.D. 10620 Georgia Ave				PHYSICIAN'S NAME (Type) JOHN J. CURRY			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/8/57		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Werner B. Humphrey ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE 4/8/57		24b. REGISTRAR'S SIGNATURE Frances Potter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1917

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4224 CERTIFICATE OF DEATH

04196

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Kensington Gardens</u>		d. STREET ADDRESS <u>3921 Military Road N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>ROSE</u> First <u>KUBN</u> Middle <u>CARSTENS</u> Last		4. DATE OF DEATH Month <u>APRIL</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-68</u>
9. AGE (In years last birthday) yrs. <u>88</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>KUHN</u>		14. MOTHER'S MAIDEN NAME <u>FRAILEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, acute</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis, advanced</u> DUE TO (c) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>1644</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinomatosis of abdomen</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 2, 1957</u> , to <u>April 2, 1957</u> , that I last saw the deceased alive on <u>April 2, 1957</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		M.D. <u>3921 Ingomar St. N.W.</u> DATE SIGNED <u>4.2.57</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		<u>Wash 15 DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>4/6/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company,</u>		ADDRESS <u>Washington, D.C.</u>	
24a. RECEIVED BY REGISTRAR <u>1957</u>		24b. REGISTRAR'S SIGNATURE <u>Francesca Potter</u>	

RECEIVED

APR 4 1957

BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4225

CERTIFICATE OF DEATH

04197

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 8 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 808 WAYNE AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last DAVID ELDER CATHRO				4. DATE OF DEATH Month Day Year APRIL 4 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 5, 1890	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLASTERER (retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. GOVERNMENT		11. BIRTHPLACE (State or foreign country) DUNDEE, SCOTLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM CATHRO				14. MOTHER'S MAIDEN NAME JEAN HARRIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW # 1 034-07-1759		17. INFORMANT Address Mrs. Sybella M. Cathro, 808 Wayne Ave. Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY OCCLUSION DUE TO (c) ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSION							INTERVAL BETWEEN ONSET AND DEATH 3 minutes 5 minutes 5 minutes
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV. 1953, to APR. 4, 1957, that I last saw the deceased alive on APR. 4, 1957, and that death occurred at 10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel T. Kimble				ADDRESS (Street, city or town, state) 429 Fenching Drive, Silver Spring, Md.		DATE SIGNED	
PHYSICIAN'S NAME (Type) SARUCH T. KIMBLE							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/8/57		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Warner B. Humphrey, SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE 4/8/57		24b. REGISTRAR'S SIGNATURE	

BUREAU V. E.

1957

RECEIVED

4171

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fair Hill Nursing Home</u>				d. STREET ADDRESS <u>2-723 Outaouchee</u>			
3. NAME OF DECEASED (Type or print) <u>Jennie D. Clarke</u>				4. DATE OF DEATH <u>April 8</u> 19 <u>57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14, 1899</u>		9. AGE (In years last birthday) <u>58</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George F. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Hallie F. White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Norton Chukie (son) As per records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>						<u>42 hours</u>	
DUE TO (b) <u>Atherosclerosis, generalized</u>						<u>15 yrs</u>	
DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 6</u> , 19 <u>57</u> , to <u>April 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 19</u> , 19 <u>57</u> , and that death occurred at <u>9:55</u> A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.				ADDRESS (Street, city or town, state) <u>2701 Carroll Ave</u>			
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>				DATE SIGNED <u>Apr. 8, 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/12/57</u>		<u>Wash. National</u>		<u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> ADDRESS <u>Wash, DC</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>3-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>Justina Kelly</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4226

CERTIFICATE OF DEATH

04199

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
c. LENGTH OF STAY in 1b <u>7 years</u>		d. STREET ADDRESS <u>25 Grafton St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>25 Grafton St., C. C., Md.</u>		* IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sara</u> First <u>Guy</u> Middle <u>Colclough</u> Last		4. DATE OF DEATH <u>April</u> Month <u>23</u> Day <u>1957</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Shannandoah, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Robert H. Guy</u>		14. MOTHER'S MAIDEN NAME <u>Sara Cooper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Oswald Colclough</u>		Address <u>Ch., Ch., Md.</u> <u>25 Grafton St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerotic heart disease</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertension</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 7, 1957</u> to <u>April 23, 1957</u> that I last saw the deceased alive on <u>April 23, 1957</u> and that death occurred at <u>5 A. M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>4861 A Battery Lane Bethesda, Md.</u> DATE SIGNED <u>4/23/57</u>			
ACTUAL SIGNATURE <u>Wilfred R. Ebrmantrout</u>		PHYSICIAN'S NAME (Type) <u>Wilfred R. Ebrmantrout</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 26, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Samuels</u> ADDRESS <u>175 Pennsylvania Ave N.W., Washington, DC</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>4-25-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 9 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										04200
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 216
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 1 1/2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.					d. STREET ADDRESS 2504 Sheraton St.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Elsie Middle Mae Last Cole					4. DATE OF DEATH Month April Day 6 Year 19 57					
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1922		9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Unemployed		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Lewis William Miller					14. MOTHER'S MAIDEN NAME Nellie Legeer					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hannibal Cole			Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arsenic poisoning - suicide 971.6 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reported to have drank some weed killer							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Frank J. Broschart M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Frank J. Broschart					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)					22b. DATE THEREOF May 57		22c. NAME OF CEMETERY OR CREMATORY 57 FORT LINCOLN		22d. LOCATION (City, town, or county) (State) DC	
23. FUNERAL DIRECTOR'S SIGNATURE ROY W. LAYTON					ADDRESS 2424-1 LAYTONSVILLE RD		24a. REC'D BY REGISTRAR DATE 4-11-57		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

BUREAU V. S.

APR 15 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4225 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04201
214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>D. O. A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Manor Shopping Center, University Blvd..</u>				d. STREET ADDRESS <u>12,706 Turkey Branch Pkwy.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gloria C Conner</u>				4. DATE OF DEATH Month Day Year <u>April 8 19 57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/12/26</u>		9. AGE (In years last birthday) <u>30</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min. <u>30</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEPAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RAYMOND CAMPBELL</u>				14. MOTHER'S MAIDEN NAME <u>THELMA WOODS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT Address <u>Mr. Charles B. Conner, 12,706 Turkey Br. Pkwy. Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>S30x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of skull</u> (c) <u>Fracture of skull</u> (e), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of facial bones</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by own car which was drifting backwards</u>					
20c. TIME OF INJURY Month, Day, Year <u>7:25 p.m. Apr. 8 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Shopping Center in Wheaton, Montgomery, Maryland</u>		20f. (City or town) (County) (State) <u>Rockville, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/11/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey,</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>4/13/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Little</u>		DATE SIGNED <u>April 8, 1957</u>	

BUREAU V. S.

1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4229

CERTIFICATE OF DEATH

04202

Reg. Dist. No.

216

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived) (If institution, residence before admission) a. STATE Virginia b. COUNTY James City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsburg	
3 NAME OF DECEASED (Type or print) First Amie Middle Lee Last Cook		4. DATE OF DEATH Month April Day 25 , Year 1957	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 3, 1935
9 AGE (in years last birthday) 21 yrs		F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Waitress Work	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Devaney Conner		14 MOTHER'S MAIDEN NAME Helen Stringfield	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO. unknown	
17 INFORMANT The Medical Record		address The Clinical Center, Bethesda 14, Maryland	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Primary congestive and chronic DUE TO Generalized sclerosis with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last or myocardial fibrosis DUE TO Myocardial fibrosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 11 months 11 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 22, 1957 to April 25, 1957 , that I last saw the deceased alive on April 25, 1957 , and that death occurred at 12:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Daniel D. Federman		DATE SIGNED 4/25/57	
PHYSICIAN'S NAME (Type) DANIEL D. FEDERMAN, M. D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 4/26/57	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Williamsburg Va.
23 FUNERAL DIRECTOR'S SIGNATURE Francis Funeral Home Inc. - 389 K St. N.W.		24a. REC'D BY REGISTRAR APR 29 1957	24b. REGISTRAR'S SIGNATURE Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4172

CERTIFICATE OF DEATH

Reg. Dist. No. 14203-3

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47x</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>3060 16th St N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Bessie Hancock Cook</u>			4. DATE OF DEATH <u>4</u> Month <u>29</u> Day <u>1957</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>Calc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-21-1874</u>	9. AGE (In years last birthday) <u>82</u> yrs	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>George P Bohrer</u>			14. MOTHER'S MAIDEN NAME <u>Eva Hancock</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp Records</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infarct of myocardium, left ventricle</u> DUE TO (c) <u>Occlusion of coronary arteries (arteriosclerosis)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>several months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis, marked</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-16</u> , 19 <u>56</u> , to <u>4-29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4-29</u> , 19 <u>57</u> , and that death occurred at <u>10:44</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>500 Underwood Street, N.W.</u> DATE SIGNED <u>5/1/57</u>							
ACTUAL SIGNATURE <u>J. H. Lohman</u>			M.D. <u>500 Underwood Street, N.W.</u>				
PHYSICIAN'S NAME (Type) <u>Charles H. W. Lohman</u>			Washington, D.C.				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St., N.W. DC</u>				24a. REC'D BY REGISTRAR <u>MAY 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. Lohman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 1 1957

RECEIVED

4230

CERTIFICATE OF DEATH

Reg. Dist. No. 042046

1. PLACE OF DEATH a. COUNTY Montgomery, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd's	
		d. STREET ADDRESS Rural	
		• IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mr. Benjamin Raymond Cooley		4. DATE OF DEATH Month April Day 20 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March, 1882
		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - retired		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Richard Edward Cooley		14. MOTHER'S MAIDEN NAME Louise Auston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Richard E. Cooley		Address 5318 Belt Rd., N.W. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 162X DUE TO Cerebral Vascular Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pulmonary Embolism (c) Branchogenic Embolism		INTERVAL BETWEEN ONSET AND DEATH 1 hr. and 30 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral vascular accident		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 April 1957 to 20 April 1957 , that I last saw the deceased alive on 19 April 1957 , and that death occurred at 11:34 A.M. , from the causes and on the date stated above			
ACTUAL SIGNATURE Merton L. White		DATE SIGNED 11/34 6-cory 20 Ave 55 20 19 57	
PHYSICIAN'S NAME (Type) Merton L. White		11134 Georgia Ave. S.S.Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/24/57	22c. NAME OF CEMETERY OR CREMATORY St. Mary's	22d. LOCATION (City, town, or county) (State) Barnesville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR 4-22-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPT. OF JUSTICE

APR 24 1957

RECEIVED

4231

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institut an Residence before adm ssion) o STATE <u>MARYLAND</u> b COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d STREET ADDRESS <u>4404 Montgomery Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>LEE</u> First <u>CRANDALL</u> Middle <u>Sr</u> Last		4. DATE. Month <u>4</u> Day <u>15</u> Year <u>1957</u> DEATH	
5. SEX <u>MALE</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-13-77</u>
9. AGE (In years last birthday) <u>80</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPAT ON (Give kind of work done during most of working life, even if retired) <u>broker</u>		10b KIND OF BUS INESS OR INDUSTRY <u>Real Estate</u>	
11. BIRTHPLACE (State or fore-ign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lee Crandall</u>		14 MOTHER'S MAIDEN NAME <u>Harriet Giers</u>	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <u>577-34-3251A</u>	
17 INFORMANT Address <u>Harriet Y. Crandall-Item# 2</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis and Myocardial infarction</u> <u>4:20:1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis, bilateral</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December, 1956</u> to <u>15 April, 1957</u> , that I last saw the deceased alive on <u>13 April, 1957</u> , and that death occurred at <u>6:35 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Homer L. Reighard</u> M.D.		DATE SIGNED <u>4/15/57</u>	
PHYSICIAN'S NAME (Type) <u>HOMER L. REIGHARD, M.D.</u>		<u>WASHINGTON 16 D.C.</u>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b DATE THEREOF <u>4/17/57</u>	22c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d LOCATION (City, town or county) (State) <u>Suitland, Md.</u>
23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a REC'D BY REGISTRAR DATE <u>4 15 57</u> 24b REGISTRAR'S SIGNATURE <u>13 mile Dr. Lincolnton</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 17 1957
BUREAU V. S.

4232

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Oregon b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Francis Middle George Last Daggett		4. DATE OF DEATH Month April Day 23 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24, 1914
9. AGE (in years last birthday) 42 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Seaman		10b. KIND OF BUSINESS OR INDUSTRY Merchant Marine	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Daggett		14. MOTHER'S MAIDEN NAME Katherine Pearce	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 024-03-4779	
17. INFORMANT The Medical Record		18. ADDRESS The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ventricular fibrillation at Surgery 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1-hemorrhagic fever - toxic Stenosis DUE TO (c) several years			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 3, 1957 to April 23, 1957 , that I last saw the deceased alive on April 23, 1957 , and that death occurred at 1:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard J. Sanders M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4/23/57	
PHYSICIAN'S NAME (Type) RICHARD J. SANDERS, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/57	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Portland, Oregon	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS Wash., D.C.	
24a. RECEIVED BY REGISTRAR DATE APR 25 57		24b. REGISTRAR'S SIGNATURE Al. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU A. B.

1957

RECEIVED

4233

CERTIFICATE OF DEATH

Reg. Dist. No. 276

04207

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE District of Columbia	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c LENGTH OF STAY IN 1b 140 days	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e STREET ADDRESS 3434 - 34th Street, N.W.	
3. NAME OF DECEASED (Type or print) First Margaret Middle Viola Last Dawson		4. DATE OF DEATH Month April Day 29 , Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 22, 1902
9. AGE (In years last birthday) 54 yrs		10. IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Typist		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Williams		14. MOTHER'S MAIDEN NAME May Andrews	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO unknown	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Insufficiency 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) metastatic carcinoma DUE TO (c) Carcinoma of Breast		INTERVAL BETWEEN ONSET AND DEATH 5 days 1 year 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 10, 1956 , to April 29, 1957 , that I last saw the deceased alive on April 29, 1957 , and that death occurred at 3:00 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William J. Pieper M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
DATE SIGNED 4/30/57			
PHYSICIAN'S NAME (Type) William J. Pieper, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/2/57	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE W.K. Huntemann & Son		ADDRESS 5732 Georgia Ave N.W.	
24a. REC'D BY REGISTRAR 5-2-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 6 1957

BUREAU V. T.

Howard

Simonsville

16 Dillwood Drive

• IS RESIDENCE
ON A FARM?
YES ☐ NO ☐

Yes

R IF UNDER 24 HRS

112 CITIZEN OF WHAT COUNTRY?

Gertrude May George

117 INFORMANT

Respiratory failure

grenoble

INTERVAL BETWEEN ONSET AND DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

(State)

ADDRESS (Street, city or town, state)

PHYSICIAN'S NAME (Type) Ruth Standard, M. D. Washington San. & Hosp. Takoma Park, Md.

(5 total)

24. REGISTRAR'S SIGNATURE

V5 A15 (4)
15M 9/55

2075323XVV Takoma Park, Md.

RECEIVED

MAY 1 1957

BUREAU V. S.

4234

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Mountgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Takoma Park</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN 1b <u>6 days</u>				d. STREET ADDRESS <u>6821 Eastern Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedarcroft San + Hosp</u>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Madge</u> Middle <u>C</u> Last <u>Douglas</u>				4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-20-1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs		IF UNDER 1 YEAR Months <u>4</u> Days <u>24</u> Hours <u>19</u> Min. <u>57</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, DC.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Byron C. Coon</u>		14. MOTHER'S MAIDEN NAME <u>Janet M. Pherson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Willard R. Douglas, (same as #2)</u>		Address <u>(same as #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>" arteriosclerosis</u> DUE TO (c) <u>Korotkoff's Syndrome</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 18, 1957</u> to <u>April 24, 1957</u> , that I last saw the deceased alive on <u>April 24, 1957</u> , and that death occurred at <u>7:35 P.</u> M, from the cause and on the date stated above.							
ACTUAL SIGNATURE <u>R.B. Thibadeau</u>				M.D. <u>Columbia Rd. Silver Spring, MD</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD-B. THIBADEAU</u>				DATE SIGNED <u>4/24/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 27 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Wallers, 254 Carroll St NW</u>				ADDRESS <u>254 Carroll St NW</u>		24b. REC'D BY REGISTRAR DATE <u>4/24/57</u>	
				24c. REGISTRAR'S SIGNATURE <u>Frances Carter</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 29 1957

BUREAU V. S.

4235

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Silver Spring,</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedarcroft San. & Hosp</u>				d. STREET ADDRESS <u>508 Thayer</u>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Emily W. Dowling</u>				4. DATE OF DEATH <u>(12:10)</u> Month <u>April</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14, 1914</u>	9. AGE (In years last birthday) <u>42</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>FRIEND P. WILLIAMS</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME <u>ALMA HORTON</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Husband</u> Address <u>508 Thayer, Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acidosis</u> DUE TO <u>Insanition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Psychoneurotic Reaction</u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>4-20</u> 19 <u>57</u> to <u>4-21</u> 19 <u>57</u> that I last saw the deceased alive on <u>4-21</u> 19 <u>57</u> and that death occurred at <u>12:10</u> <u>noon</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cedarcroft San. & Hosp. R#2 St. Spg. Md</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Alvin J. Kistler</u> M.D. <u>Cedarcroft San. & Hosp. R#2 St. Spg. Md</u>							
PHYSICIAN'S NAME (Type) <u>Alvin J. Kistler, House Physician</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR 24 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MOUNTAIN GROVE CEM. BRIDGEPORT</u>		22d. LOCATION (City, town, or county) (State) <u>CONN.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James P. Miller</u>				24a. REC'D BY REGISTRAR <u>APR 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James P. Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

APR 23 1957

RECEIVED

4174 CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>		d. STREET ADDRESS <u>4811 Westway Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Bertna</u> Middle <u>Tompkins</u> Last <u>DYSON</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-80</u>
9. AGE (In years last birthday) yrs. <u>76</u>		10. IF UNDER 1 YEAR: Months <u>25</u> Days <u>25</u> Hours <u>1957</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dept of Agriculture</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rhode Island</u>	
11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Horace Tompkins</u>		14. MOTHER'S MAIDEN NAME <u>Jeannette Stillwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>60X</u>	
17. INFORMANT <u>Wash. San. & Hosp. Records</u>		Address <u>Takoma Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary failure</u> <u>445X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> (c) <u>heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u> <u>20 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>60X</u> <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> to <u>Apr 25</u> , 19 <u>57</u> that I last saw the deceased alive on <u>4/24</u> , 19 <u>57</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>500 UNDERWOOD STREET N.W.</u>			
ACTUAL SIGNATURE <u>E. H. Wolohin</u> M.D.		DATE SIGNED <u>4/25/57</u>	
NAME (Type) <u>E. H. Wolohin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-29-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>	22d. LOCATION (City, town, or county) (State) <u>Ft. Myer, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph E. Sanders</u>		24. REG. DUTY REGISTRAR'S SIGNATURE <u>John W. Jones</u>	
ADDRESS <u>1756 P. Ave. N.W.</u>		DATE <u>Apr 26 1957</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 1 1957

RECEIVED

4236

CERTIFICATE OF DEATH

Reg. Dist. No.

04212

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 24 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lawrence Middle Edward Last Emge		4. DATE OF DEATH April 17 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/07
9. AGE (In years last birthday) 49		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supply Specialist - Veterans Adm. U.S. Gov't		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Joseph Edward Emge	
14. MOTHER'S MAIDEN NAME Mary Gill		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, If yes, give year and date of service) yes N.W. #2	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Lilly Emge Address as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Ventricular fibrillation DUE TO acute posterior infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary-arteriosclerotic heart disease 4 yrs DUE TO Coronary-arteriosclerotic heart disease (c)			INTERVAL BETWEEN ONSET AND DEATH 36 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS A JTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p m 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 54 19 to 4/17/57 19 that I last saw the deceased alive on 4/17/57 19 and that death occurred on 4/17/57 M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Bernard J. Walsh M.D.		900-1724 St. N.W. - 4/17/57	
PHYSICIAN'S NAME (Type) BERNARD J. WALSH		Mark. B. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/22/57	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 4-22-57	24b. REGISTRAR'S SIGNATURE Warner E. Humphrey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 21 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4237

CERTIFICATE OF DEATH

Reg. Dist. No.

04213

211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admittance) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clagettsville			c. LENGTH OF STAY IN 1b 15 Years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clagettsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First C Middle E Last Emswiler				4. DATE OF DEATH Month April Day II Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21 1878		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Emswiler				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Alice Emswiler		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4-2-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 30 , 19 49 to April 11 , 19 57 , that I last saw the deceased alive on April 8 , 19 57 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 4/11/57 ACTUAL SIGNATURE James P. Kerr M.D. James P. Kerr PHYSICIAN'S NAME (Type) James P. Kerr Damascus, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 13 1957		22c. NAME OF CEMETERY OR CREMATORY Flower Hill		22d. LOCATION (City, town, or county) (State) Redland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond Barber ADDRESS Laytonsville, Md.				24a. REC'D BY REGISTRAR DATE April 17/57		24b. REGISTRAR'S SIGNATURE Della W. Burdette	

BUREAU V. E.

APR 22 1957

RECEIVED

4238

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 504 Fleetwood Street				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. STREET ADDRESS 504 Fleetwood Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CAROL Middle LUCILLE Last ENOS				4. DATE OF DEATH Month April Day 10th Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 21st, 1944	
9. AGE (In years last birthday) 12 yrs		IF UNDER 1 YEAR Months 12 Days 10 Hours 15 Min		IF UNDER 24 HRS Hours 15 Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY Grade school		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Linwood E. Enos				14. MOTHER'S MAIDEN NAME Carrie A. Phillips			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Linwood E. Enos, 504 Fleetwood St. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation - vomitus. 475X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Upper respiratory infection DUE TO (c) 24 hours						INTERVAL BETWEEN ONSET AND DEATH Acute	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 19				20g. (County) 19		20h. (State) 19	
21. I certify that I attended the deceased from MAR 1957 to April 10, 1957 , that I last saw the deceased alive on April 10, 1957 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ernest C. Sarao				ADDRESS (Street, city or town, state) 7006 New Hampshire Ave Takoma Park, Md.			
PHYSICIAN'S NAME (Type) Ernest C. Sarao				DATE SIGNED April 19 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pe. Geo. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR 15 1957		24b. REGISTRAR'S SIGNATURE Frances Catter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The form required that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 17 1957

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04215

4285 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		STATE MARYLAND		COUNTY MONTG.			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westmoreland Hills		LENGTH OF STAY (in this place)		CITY (if outside corporate limits, write RURAL and give nearest town) OR TOWN Westmoreland Hills			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5138 MASS. AVE.				STREET ADDRESS (If rural give location) 5138 MASS. AVE.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ANDREW (Middle) BROWN E (Last) EVANS				(Month) APRIL (Day) 23 (Year) 1957			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 5/4/88	9. AGE last birthday 68 yrs	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Own practice		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Evans				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. John W. Robinson 9313 Adeline Dr. Bethesda, Md.			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Acute coronary thrombosis (myocardial infarction) minutes				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) Generalized arteriosclerosis years							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) He had a myocardial infarction about 10 years ago, has been under care of Dr. Paul Lichtman, a cardiologist since then, saw him about 3 mo. ago. I was called as he breathed his last and pronounced him dead.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION The Coroner told me to sign the certificate		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 1957....., and that death occurred at 11:45 PM, from the causes and on the date stated above.							
SIGNATURE C. P. Ryland				ADDRESS (Street, city, town, state) DATE SIGNED M.D. 4400 - 49th St. N.W. Washington, D.C. 4-24-57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF 4/26/57		NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		LOCATION (City, town, or county) (State) Prince George County, Md.	
24. REC'D BY REGISTRAR DATE 4/20/57		REGISTRAR'S SIGNATURE Shary Parrelly		25. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, D.C.		ADDRESS	

RECEIVED

1957

RECEIVED

4240

CERTIFICATE OF DEATH

Reg. Dist. No.

04216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 day, 15 hr's	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. STREET ADDRESS 3709 Chevy Chase Lake Drive	
3. NAME OF DECEASED (Type or print) First Carrie Middle Gertrude Last Evans		4. DATE OF DEATH Month April Day 27 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1874
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James H. Shreve		14. MOTHER'S MAIDEN NAME Caroline Ray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Stephen H. Evans		Address Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis. DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH 2 days 10 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Hour 9:15 p. m. Month April Day 19 Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) ----- (County) ----- (State) -----
21. I certify that I attended the deceased from 25 Apr 57 to 27 Apr 1957 that I last saw the deceased alive on 26 Apr 1957 , and that death occurred at 4:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5522 Western Ave DATE SIGNED 27 Apr 57			
ACTUAL SIGNATURE A. H. RICHWINE M.D.		PHYSICIAN'S NAME (Type) A. H. RICHWINE	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/29/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company		ADDRESS 2901 14th St. N.W. Washington, D.C.	
24a. RECEIVED BY REGISTRAR APR 28 1957		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4241 Item 2 Filed *4-27-57* at *St*
CERTIFICATE OF DEATH Item 9 Filed *4-27-57* at *St*

04218

Reg. Dist. No. *214*

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Unknown</i>	
3. NAME OF DECEASED (Type or print) <i>ALBERTA A FAIRALL</i>		4. DATE OF DEATH <i>April 25 1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-22-68 89</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Tamul md.</i>	
13. FATHER'S NAME <i>James Hughes</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Owens</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (If yes, give war or dates of service)		17. INFORMANT Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>181X</i> <i>of acute myocardial infarction</i> DUE TO (b) <i>metastatic carcinoma</i> DUE TO (c) <i>carcinoma of bladder</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>5 hr.</i> <i>6 mo.</i> <i>1 1/2 yr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from *March 1957*, to *4-25-57*, that I last saw the deceased alive on *4-22-57*, and that death occurred on *12:40 AM*, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) *1817 5th St NW Washington DC* DATE SIGNED *4-25-57*

ACTUAL SIGNATURE *John R. Jones* M.D. *John R. Jones*

PHYSICIAN'S NAME (Type) *John R. Jones*

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>4-27-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln</i>	22d. LOCATION (City, town, or county) (State) <i>Columbia Md. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Turner Home - DC</i> ADDRESS		24a. REC'D BY REGISTRAR DATE <i>4/26/57</i>	24b. REGISTRAR'S SIGNATURE <i>Frances Potter</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4175

CERTIFICATE OF DEATH

Reg. Dist. No.

04219

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sav. & Hospital</u>				d. STREET ADDRESS <u>2205 California St. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Helen Fay</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-31-81</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
13. FATHER'S NAME <u>Edward Allen Fay</u>				14. MOTHER'S MAIDEN NAME <u>Mary Bratshaw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Allen B. Fay</u>		Address <u>Nephew - 2 Ardmore Circle, Wash DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepato-Renal Syndrome due to</u> DUE TO (b) <u>Terminal Stage of Portal Cirrhosis</u> DUE TO (c) <u>With Esophageal Varices and Acutes</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 1955, to <u>April 22</u> , 1957, that I last saw the deceased alive on <u>April 22</u> , 1957, and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>				ADDRESS (Street, city or town, state) <u>809 Davis Ave, Takoma Park, Md</u>			
DATE SIGNED <u>4/22/57</u>							
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>				<u>809 Davis Ave, Takoma Park, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cms</u>		22d. LOCATION (City, town or county) <u>Bethesda Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cheng Chao Fung</u>				ADDRESS <u>5103 Wisconsin Ave NW Wash DC</u>		24a. REG'D BY REGISTRAR DATE <u>4-25-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bennie M. Shorrock</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 19 1957

BUREAU V. S.

4176

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 17 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d STREET ADDRESS 8359 COLESVILLE ROAD				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First MIDDLE Last JOSIAH DEMING FERGUSON				4. DATE OF DEATH Month Day Year APRIL 13 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-12-91	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER - retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM P. F. FERGUSON				14. MOTHER'S MAIDEN NAME GRACE HATHAWAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WN # 1		17. INFORMANT Mrs. Louise C. Ferguson, 8359 Colesville Rd. Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 weeks. 2-3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 10, 1940, to April 12, 1957, that I last saw the deceased alive on April 12, 1957, and that death occurred at 8:37 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. B. WARDROP M.D.				ADDRESS (Street, city or town, state) 837 Bonifant St. Silver Spring, Md.			
DATE SIGNED 4/15/57				DATE SIGNED 4/15/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 4/13/57		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey,				ADDRESS SILVER SPRING, MD.			
24a. REC'D BY REGISTRAR DATE 4/15/57		24b. REGISTRAR'S SIGNATURE J. H. H. H.					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 17

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4291

CERTIFICATE OF DEATH

04221

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 4ix	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waverly Sanitarium				d. STREET ADDRESS 1825 G Street, N. W.		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle FRANCIS Last				4. DATE OF DEATH Month April Day 14 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 27, 1872	
9. AGE (In years last birthday) 85 yrs		IF UNDER 1 YEAR Months 0 Days 17 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Shandon, Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Abner Francis				14. MOTHER'S MAIDEN NAME Martha Ann Vaughan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Dr. Charles R. Armstrong Address 7605 Meadow La. Chevy Chase, Md.			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fever of unknown origin DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis, generalized, severe arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 19 50 to April 19 57 , that I last saw the deceased alive on April 11 19 57 , and that death occurred at 7:30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1150 Conn. Ave., N.W. Wash. D.C. DATE SIGNED F. G. MacMURRAY							
ACTUAL SIGNATURE F. G. MacMURRAY M.D.				PHYSICIAN'S NAME (Type) F. G. MacMURRAY 1150 Conn. Ave., N.W., Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial-transit 4-16-57				Shandon Cemetery		Shandon, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHKEY ADDRESS Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 4-16-57		24b. REGISTRAR'S SIGNATURE Bessie M. Lee	

BUREAU V. S.

APR 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4292 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04222

Reg. Dist. No. 18

1. PLACE OF DEATH a. COUNTY Montgomery <div style="text-align: right;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 20 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chestnut Lodge				d. STREET ADDRESS Chestnut Lodge		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frieda First Fromm-Reichmann Middle Reichmann Last				4. DATE OF DEATH 4/28/57 Month Day Year			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/23/1889	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Adolph Reichmann				14. MOTHER'S MAIDEN NAME Klara			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Chestnut Lodge Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Thrombosis Left Descend Coronary Artery 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Atherosclerosis, Coronary Art. Arteriosclerosis (c) ? DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found dead in bath tub filled with water			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 4/29/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/1/57		22c. NAME OF CEMETERY OR CREMATORY St. Sebastian Cemetery		22d. LOCATION (City, town, or county) (State) Hyattsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Nanzanay + Son - 3501 14th St N.W.				24a. REC'D BY REGISTRAR 5-3-57		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5/6/57 Lowell Kratzberg per E.C.

BUREAU Y. I.

MAY 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01223
223

4177

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>802 Tanley Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Oliver</u> Middle <u>Charles</u> Last <u>Eyles</u>		4. DATE OF DEATH Month <u>4</u> - Day <u>14</u> - Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-7-01</u>
9. AGE (In years last birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Conn</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver C. Eyles</u>		14. MOTHER'S MAIDEN NAME <u>Lula Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-09-6190</u>	
17. INFORMANT <u>Washington Sanitarium & Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>3521</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Generalized arteriosclerotic vascular disease - 2 yrs.</u> DUE TO (c) <u>Possible underlying mild diabetes ?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>General myocardial disease on a coronary artery basis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>April</u> , 19 <u>54</u> , to <u>April 14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 14</u> , 19 <u>57</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Ernest E. Harmon</u> M.D.		ADDRESS (Street, city or town, state) <u>9301 Colesville Road, Silver Spring, Maryland</u>	
DATE SIGNED <u>4/14/57</u>		22a. REC'D BY REGISTRAR <u>Johnston Dodd</u>	
22b. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM CHURCH CEMETERY</u>		22c. LOCATION (City, town, or county) (State) <u>GLASTONBURY, CONNECTICUT</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u>		24. REGISTER'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

RECEIVED

APR 12 1967

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04224

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 218

4242

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg c. LENGTH OF STAY in 1b 2 mo. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oakmont Ave. RFD #3		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 1 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg d. STREET ADDRESS Oakmont Ave. RFD # 3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Leslie Gossett		4. DATE OF DEATH Month 4 Day 26 Year 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/05
9. AGE in years last birthday 52 yrs.		IF UNDER 1 YEAR Months 5 Days 26	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY S.C.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 247-05-1711	
17. INFORMANT Nancy Gossett(wife)		Address Same # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (b) 420.1 DUE TO Coronary Occlusion (a), stating the underlying cause last. (c) 420.1		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-57	
22c. NAME OF CEMETERY OR CREMATORY Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.		24a. REC'D BY REGISTRAR Apr 29-57	
		24b. REGISTRAR'S SIGNATURE Abdul G. Cooke	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04225

214

4243

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived (If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home		d. STREET ADDRESS 2606 Arcola Avenue	
3. NAME OF DECEASED (Type or print) Anna C. Gravalles		4. DATE OF DEATH Month 4 Day 25 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/20/77
9. AGE (In years last birthday) yrs. 79		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles H. Butt		14. MOTHER'S MAIDEN NAME Anna C. Schryer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. George Buckler		2606 Arcola Ave. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 yr 5 yrs 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1947 to April 1957 , that I last saw the deceased alive on April 25 1957 , and that death occurred at 11:22 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE H. F. Kreuzburg		ADDRESS (Street, city or town, state) DATE SIGNED 7852 16 St. NW 4/25/57	
PHYSICIAN'S NAME (Type) H. F. Kreuzburg		Wash DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 4/27/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR 29 1957	
24b. REGISTRAR'S SIGNATURE Francis Potter			

RECEIVED

APR 23 1957

BUREAU V. S.

4244

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		e. STREET ADDRESS <u>5211 Roosevelt St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Halford</u> Middle <u>Robert</u> Last <u>GREENLEE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 Dec. 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy (Retired)</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Archibald W. Greenlee</u>		14. MOTHER'S MAIDEN NAME <u>Olive Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>Yes 9-7-01 to 6-30-40</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>(Son) Halford R. Greenlee, Jr. (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture Aortic Aneurysm</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>17 April</u> , 19 <u>57</u> , to <u>22 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>22 April</u> , 19 <u>57</u> , and that death occurred at <u>12:10 P.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>R. J. Cales</u>		M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>R. J. CALES, LCDR, MC, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4-25-57</u>	<u>Arlington Nat'l Cemetery</u>	<u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. H. K. Murray</u>		ADDRESS <u>1557 Wisconsin Ave., Bethesda, Md.</u>	24a. REC'D BY REGISTRAR <u>4-22-57</u>
		24b. REGISTRAR'S SIGNATURE <u>Mary E. Staschky</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 24 1967
BUREAU W. A.

4245

CERTIFICATE OF DEATH

Reg. Dist. No.

212

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Edgar Last Gregg		4. DATE OF DEATH Month April Day 11 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/72
9. AGE (In years last birthday) 85		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elisha Gregg		14. MOTHER'S MAIDEN NAME Catherine Stevens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1 NO		16. SOCIAL SECURITY NO 110	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Failure 586X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Biliary Cirrhosis of Liver (c) Hepatic Duct Obstruction.		INTERVAL BETWEEN ONSET AND DEATH 2 days 3 mo. 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/2, 1957 , to 4/11, 1957 , that I last saw the deceased alive on 4/11/57 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) Sandy Spring, MD	
PHYSICIAN'S NAME (Type) C. H. LIGON		DATE SIGNED 4/11/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/14/57 Burial		22b. DATE THEREOF 4/14/57	
22c. NAME OF CEMETERY OR CREMATORY Pine Grove		22d. LOCATION (City, town, or county) (State) Mont Airy, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Helton, Barnesville, Md		24a. REC'D BY REGISTRAR 4/15/57	
24b. REGISTRAR'S SIGNATURE Charles W. Helton			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4246 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **021228**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN Is 8 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woodmore Cleaners, 10119 Colesville Rd.				d. STREET ADDRESS 1426 K St., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Gregory Last				4. DATE OF DEATH Month 4/25/57 Day 19 Year			
5. SEX male	6. COLOR OR RACE ool	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1904		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY laundry		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? ITALY	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Rosa Lanton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Police Record Address Dorthy Johnson			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4.30.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last, DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4/26/57		22c. NAME OF CEMETERY OR CREMATORY Hall Bros. Funeral Home		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Anander				24. REC'D BY REGISTRAR APR 30 1957			
ADDRESS Bookville, Maryland				25. REGISTRAR'S SIGNATURE Frances Potters			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 30 1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

01223
212

4247

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Poolesville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD - Poolesville		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Poolesville	
f. STREET ADDRESS RFD - Poolesville		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ERNEST Middle Mazo Last GRUBB		4. DATE OF DEATH Month April Day 24 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/87
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 4 Days 25	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. - Secy.		10b. KIND OF BUSINESS OR INDUSTRY Y. M. C. A.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Winton E. Grubb		14. MOTHER'S MAIDEN NAME Catherine Lindamood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 114-26-5885	
17. INFORMANT Mrs Mabel L. Grubb- Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Parkinson's Disease DUE TO (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec , 1952, to 24 April , 1957, that I last saw the deceased alive on 24 April , 1957, and that death occurred at 10 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John G. Fawcett M.D.		ADDRESS (Street, city or town, state) P.O. Baycol, Md 4/25/57	
PHYSICIAN'S NAME (Type) JOHN G. FAWCETT MD		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/29/57	22c. NAME OF CEMETERY OR CREMATORY Presby. Church Cem.	22d. LOCATION (City, town, or county) (State) Darnestown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumpfrey-Bethesda, Md.		24a. REC'D BY REGISTRAR APR 29 1957	
24b. REGISTRAR'S SIGNATURE Charles Elgin			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. K.

APR 29 1967

RECEIVED

4248

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8401 Seven Locks Road</u>				/d. STREET ADDRESS <u>8401 Seven Locks Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>Guttersen</u> Last <u>Guttersen</u>				4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/22/1877</u>	
9. AGE (in years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months <u>5</u> Days <u>10</u>		IF UNDER 24 HRS Hours <u>10</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>		11. BIRTHPLACE (State or foreign country) <u>Minnesota, Gallatin Co</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>516-16-1842</u>		17. INFORMANT <u>Alston Guttersen, 8401 Seven Locks Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma, right lung</u> <u>162x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease Chronic Emphysema</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 13, 1953</u> , to <u>April 2, 1957</u> , that I last saw the deceased alive on <u>April 1, 1957</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert G. Angle</u>				ADDRESS (Street, city or town, state) <u>5009 Del Ray Ave., Bethesda, Md.</u> DATE SIGNED <u>April 2, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Robert G. Angle, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Trans.</u>		22b. DATE THEREOF <u>4/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sun Set Hills</u>		22d. LOCATION (City, town, or county) (State) <u>Minnesota, Gallatin Co.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>6-3-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 17 1907

RECEIVED

Item 20b Film G2 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5-6-57 jp

4249

License 14324 5-3-57

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 4 1/2 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 x d. STREET ADDRESS 5125 8th St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle Hamilton Last Hamilton		4. DATE OF DEATH Month Apr Day 20 Year 1957	
5. SEX female	6. COLOR OR RACE col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-6-1920
9. AGE (In years, last birthday) 3 yrs.		10. IF UNDER 1 YEAR OF AGE, UNDER 24 HRS. Months 3 Days 19 Hours 19 Min 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Unknown		Address Unknown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute traumatic shock DUE TO Caprol, Contusion - Ruptured spleen. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture, both bones, Rt leg DUE TO Fracture, both bones, Rt leg PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in car passing other vehicle when struck head on.	
20c. TIME OF INJURY Month, Day, Year 6:47 a.m. 4/20/57		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) street		20f. (City or town) Bethesda (County) Montg. (State) Ma.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/20/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/24/57		22b. DATE THEREOF 4/24/57	
22c. NAME OF CEMETERY OR CREMATORY WILLIAMSBURG,		22d. LOCATION (City, town, or county) VIRGINIA (State) VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Harris Co., 1432 4th St. N.W.		24a. REC'D BY REGISTRAR APR 29 1957	
ADDRESS W.E. Harris Co., 1432 4th St. N.W.		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 29 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01232

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 215

4250

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 37 hrs 5 mi		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 4-18			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.				d. STREET ADDRESS 5125 8th St. N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maurice B Hamilton				4. DATE OF DEATH 4/21/57 Month Day Year			
5. SEX male	6. COLOR OR RACE col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/30/1908		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WALLIE HAMILTON SR				14. MOTHER'S MAIDEN NAME EMMA HILL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Hosp. Records - Wallie Hamilton SR Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Delayed Traumatic Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral confusion, Fractured pelvis DUE TO (c) Auto Accident							INTERVAL BETWEEN ONSET AND DEATH 37 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Was driver of car involved in auto. accident					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 6:47 P.M. 4/20/57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Bethesda Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-27-57		22c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.C. Jarvis Co 1432 You St. NW ADDRESS				24a. REC'D BY REGISTRAR DATE 4/26/57		24b. REGISTRAR'S SIGNATURE Mary Carroll	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. B.

APR 13 1957

RECEIVED

4251

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>Montg</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown. R F D #1</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x. Germantown</u>		Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>William</u> <u>Clinton</u> <u>Harding</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 15-1867</u>
9. AGE (in years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR: Months <u>3</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired B&O RR Employee.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland (Frederick Co)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Benjamin Harding</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Howard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Benjamin J. Harding. Germantown. Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 444. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart</u> DUE TO <u>Disease</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 26, 1957</u> , to <u>Apr. 26, 1957</u> , that I last saw the deceased alive on <u>Apr. 26, 1957</u> , and that death occurred at <u>6:20</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D.		ADDRESS (Street, city or town, state) <u>24 N. Summit Ave. Gaithersburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Jack Schumacher M.D.</u>		DATE SIGNED <u>4-26-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4-29-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg. Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u>		ADDRESS <u>Gaithersburg. Md.</u>	
24a. REC'D BY REGISTRAR <u>Apr. 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Abraham J. Cooke</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

MAY 1 1957

RECEIVED

4252

CERTIFICATE OF DEATH

Reg. Dist. No

04234

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING,	
c. LENGTH OF STAY IN 1b 20 yrs.		d. STREET ADDRESS 634 RITCHIE AVE.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 634 RITCHIE AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last NELLIE HARDY		4. DATE OF DEATH Month Day Year APRIL 7 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/29/80
9. AGE (In years less birthday) yrs 76		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) PENN COUNTY, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN EDWARD JONES		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Address Mrs. Charles G. Rose, 634 Ritchie Ave. Silver Spring, Maryland		INTERVAL BETWEEN ONSET AND DEATH 6 mos. 10	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic lymphatic leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT. 1956 to APR. 1957, that I last saw the deceased alive on APR. 1957, and that death occurred at 10:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Seruch T. Kimble M.D.		22. PHYSICIAN'S NAME (Type) SERUCH T. KIMBLE	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/9/57	
22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 11200 E. RUMPLEY SILVER SPRING, MARYLAND		24a. REC'D BY REGISTRAR DATE 4/8/57	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, on any event within 72 hours after death.

RECEIVED

PR 19 1957

BUREAU V. E.

4253

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>Mason Drive, Rockville</u>	
3. NAME OF DECEASED (Type or print) <u>Patricia Ann Harri-day</u>		4. DATE OF DEATH <u>April 12 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18/57</u>
9. AGE (In years last birthday) <u>4</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John A Harri-day</u>		14. MOTHER'S MARDEN NAME <u>Della M Crockett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>mother</u>	
17. INFORMANT <u>(same)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Very immature premature</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 8, 1957</u> to <u>April 12, 1957</u> ; that I last saw the deceased alive on <u>April 12, 1957</u> , and that death occurred at <u>7:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vincent L. Donnell</u> M.D.		ADDRESS (Street, city or town, state) <u>8218 Wisc Ave Rockville, Md</u>	
DATE SIGNED <u>4/17/57</u>			
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/21/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 20 1957
U.S. AIR FORCE

CERTIFICATE OF DEATH

Reg. Dist. No.

04236
216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville - Rural</u>			
c. LENGTH OF STAY IN 1b <u>35 days</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>G</u> Last <u>Hebron</u>				4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 20, 1922</u>	
9. AGE (In years last birthday) <u>65</u> yrs		IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u> Hours <u>15</u> Min <u>00</u>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Farm laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Richard Hebron</u>				14. MOTHER'S MAIDEN NAME <u>Susie Driver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT Address <u>General Delaney</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>518x Spontaneous Pneumothorax & Subcut Emphysema.</u>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Broken blood vessel in lung</u>							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1957</u> to <u>April 1957</u> that I last saw the deceased alive on <u>3 am</u> 1957, and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Michael J. White</u> M.D.				DATE SIGNED <u>5 Apr 1957</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/6/57</u>		<u>St Paul</u>		<u>Summerville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surnden</u> ADDRESS <u>Rockville, Md</u>				24a. REC'D BY REGISTRAR <u>APR 8 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 9 1957

BUREAU V. S.

4178

CERTIFICATE OF DEATH

Reg. Dist. No.

222

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington San. & Hosp.</u>				d. STREET ADDRESS <u>1009 Notley Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Agnes Elizabeth Hecht</u>				4. DATE OF DEATH Month Day Year <u>April 20 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-3-73</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>		13. FATHER'S NAME <u>JOHN D. MacNair</u>		14. MOTHER'S MAIDEN NAME <u>MARY Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Chart (Hosp. records)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis with myocardial infarction</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>April</u> 19 <u>56</u> , to <u>April 20</u> 19 <u>57</u> , that I last saw the deceased alive on <u>April 20</u> 19 <u>57</u> , and that death occurred at <u>529</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr.</u>				ADDRESS (Street, city or town, state) <u>9301 Coleridge Rd., Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>BENNET A. PORTER, JR.</u>				DATE SIGNED <u>April 20, 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRANS. & BURIAL</u>		<u>4/23/57</u>		<u>GREENWOOD CEMETERY</u>		<u>BROOKLYN, NEW YORK</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Rumphrey</u>				ADDRESS <u>8434 Longview Rd.</u>		24a. REC'D BY REGISTRAR <u>23 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. H. Wilson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 24 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. *d 10*

04238

4255

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6424 - 79th Street				d. STREET ADDRESS 6424 - 79th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Arthur Middle Franklin Last HILL				4. DATE OF DEATH Month April Day 18 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 27, 1880	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 5 Days 21		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov. Army Engineer				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Cropley, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Levi Hill				14. MOTHER'S MAIDEN NAME Julie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Dorothy A. Wright, 6424 79th St. Cabin John			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Shotgun wound in left chest DUE TO (c) sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) John							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self-inflicted shotgun wound in left chest			
20c. TIME OF INJURY Hour 2:46 p. m. 4/18 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cabin John Montg. Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/22/57		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	
				22d. LOCATION (City, town, or county) (State) Rockville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE 4-22-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

RECEIVED

APR 24 1957

BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 8 Film G214 5-1-57 et
4256
CERTIFICATE OF DEATH

Reg. Dist. No.

04289
214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville,				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Silver Spring, R. F. D. # 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lucy First McAllister Howard Last				4. DATE OF DEATH April 22 1957			
5. SEX fem	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1874		9. AGE (In years last birthday) 83 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Albert Mc Allister				14. MOTHER'S MAIDEN NAME Rachel Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Florence Boston Address Silver Spring, Md. R. F. D. # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Embolism DUE TO Cardiorenal Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma Hepatica (c) Arthritis, Asthma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 20yrs. 14 mos.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 20, 1956 to April 22, 1957 , that I last saw the deceased alive on April 22, 1957 , and that death occurred at 2 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Webster Sewell M.D.				ADDRESS (Street, city or town, state) Norbeck, RFD 1 Silver Spring, Md.			
PHYSICIAN'S NAME (Type) Webster Sewell							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/57		22c. NAME OF CEMETERY OR CREMATORY Good Hope,		22d. LOCATION (City, town, or county) (State) Colesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sewell				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR APR 29 1957	
				24b. REGISTRAR'S SIGNATURE Frances Colley			

BUREAU V. S.

APR 10 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 File _____ et

4293

CERTIFICATE OF DEATH

Reg. Dist. No.

04240

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASH</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CC & K. S. S. M. A. M. A. R.</u>				d. STREET ADDRESS <u>12201 Rockville Pike</u>			
3. NAME OF DECEASED (Type or print) First <u>ANDREW</u> Middle <u>HUDSON</u> Last <u>HUDSON</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-30-26</u>	9. AGE (In years last birthday) <u>31</u> yrs	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Police</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Ind. Rhodes - atty for estate</u>			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TOXEMIA - GANGRENE (Rth/leg)</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic vascular Disease</u> DUE TO (c) <u>with chronic cellulitis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7-8-57</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Emphysema & Coronary heart disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1946</u> , 19____, to <u>April 24, 1957</u> , that I last saw the deceased alive on <u>April 22, 1957</u> , and that death occurred at <u>3:20 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stewart W. Dickman M.D.</u>				ADDRESS (Street, city or town, state) <u>4830 - N. S. N. W. WASH. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Stewart W. Dickman</u>				DATE SIGNED <u>4/24/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4-25-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee's Sons Co - D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>4/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>Lawrence Fragtop</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 9 1957

RECEIVED

4257

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington Grove		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marie Middle Loretta Last Hudson				4. DATE OF DEATH Month April Day 19 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/29/38 68	
9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months 7 Days 20 Hours Min 		IF UNDER 24 HRS Hours Min 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles Knott				14. MOTHER'S MAIDEN NAME Mary A. Arlen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tumor of Stomach, presumably malignant DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Obesity, diabetes. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity, diabetes.							
INTERVAL BETWEEN ONSET AND DEATH 1 yr.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Damascus, Md.	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Inne , 19 55 , to April 19, 1957 , that I last saw the deceased alive on April 19, 1957 , and that death occurred at 2:40 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. F. Meadors, M. D.				ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 4/20/57			
PHYSICIAN'S NAME (Type) G. F. Meadors, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-22-57		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harold J. Gartner				ADDRESS Belthersburg, Md.		24a. REC'D BY REGISTRAR 4-22-57	
				24b. REGISTRAR'S SIGNATURE Lester B. Lavelle			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 26 1957

RECEIVED

4253

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) BROOKE GROVE FOUNDATION		e. STREET ADDRESS 11,406 NEWPORT MILL ROAD	
3. NAME OF DECEASED (Type or print) First EDNA MARIE Middle HULL Last		4. DATE OF DEATH Month APRIL Day 28 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 21, 1896
9. AGE (in years last birthday) 61 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRACTICAL NURSE		10b. KIND OF BUSINESS OR INDUSTRY (retired)	
11. BIRTHPLACE (State or foreign country) CREAGERSTOWN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHARLES M. HULL		14. MOTHER'S MAIDEN NAME SARAH MARGARET ROBERTS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT LAWRENCE C. RABBITT		Address 11,406 NEWPORT MILL RD., SS. MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) essential hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) g. fracture of hip 2 months ago		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/15/50 , 19____, to 4/28 , 19____, that I last saw the deceased alive on 4/22/57 , 19____, and that death occurred at 6 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Patrick C. Thameson M.D. 202 Oliver St. 4/24/57 PHYSICIAN'S NAME (Type) PATRICK C. THAMESON			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 30, 1957	
22c. NAME OF CEMETERY OR CREMATORY ROCKVILLE UNION CEMETERY		22d. LOCATION (City, town, or county) (State) ROCKVILLE, MONTGOMERY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. C. Thompson		24a. REC'D BY REGISTRAR 5-7-57	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Gertrude B. Fowler	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 9 1957

BUREAU V

4759

CERTIFICATE OF DEATH

Reg. Dist. No. XXX

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Lexington Park</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>Route #1, Box 432</u>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>WILLIAM</u> Last <u>HYATT</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 April 1957</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>2</u> Hours <u>12</u> Min. <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Clarence Hyatt</u>		14. MOTHER'S MAIDEN NAME <u>Joan Pierce</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Official Navy Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fetal primary atelectasis</u> DUE TO (c) <u>12 1/2 hr</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>25 April</u> , 19 <u>57</u> , to <u>25 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>25 April</u> , 19 <u>57</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>4-26-57</u>			
ACTUAL SIGNATURE <u>John H. Mazur</u>		M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John H. Mazur, L.E.M., USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1 May 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.A. Campbell, 551 Wisconsin Ave., Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>4-26-57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary B. Parry</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 1 1957

RECEIVED

4260

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>11 hrs. 50 m</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery Co. General Hos. Inc.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 2 Colesville</u>			
d. STREET ADDRESS <u>1237 Colesville-Beltsville Rd.</u>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Jackson</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/11/57</u>	
9. AGE (In years last birthday) yrs <u>NB</u>		10. F UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>50</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Richard John Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Ann Davenport</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Richard John Jackson</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>47 h. 11 m.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>4/11</u> , 19 <u>57</u> to <u>4/12</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>4/11</u> , 19 <u>57</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard A. Yates</u> M.D.				ADDRESS (Street, city or town, state)			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>R. A. Yates, M.D.</u>				<u>Olney, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Colesville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Shorrock</u>				ADDRESS <u>Rockville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>22 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Gertrude L. Loring</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 22 1957

BUREAU V. S.

4261

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Rockbridge</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>1 mo. 1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>Raphing Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Franklin</u> Last <u>JARVIS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1 Feb. 1901</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob Jarvis</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Zimmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 1-23-42 to 3-14-43</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Official Navy Records</u>			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Lymphatic Sarcoma</u> <u>200.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>22 March</u> , 19 <u>57</u> , to <u>23 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>23 April</u> , 19 <u>57</u> , and that death occurred at <u>3:08 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Henry B. Karpinski</u> M.D.		U.S. Naval Hospital, Bethesda, Md. 4-23-57					
PHYSICIAN'S NAME (Type) <u>Henry B. Karpinski, LT, MC, USN</u>		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>205-31</u>	22b. DATE THEREOF <u>4-25-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Rockbridge County, Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u> ADDRESS <u>155 Wisconsin Ave., Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>4-23-57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary E. Gandy</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU OF

3 05 1952

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4:62

Reg. Dist. 04245

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joliet</u>			
c. LENGTH OF STAY IN 1b <u>45 min.</u>				d. STREET ADDRESS <u>1703 Houston Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital, Bethesda, Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Lee</u> Last <u>JESS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 Oct. 1936</u>		9. AGE (In years last birthday) <u>20</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Lee Jess</u>				14. MOTHER'S MAIDEN NAME <u>Verna Keithley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes 2-16-55 to 4-17-57</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Official Navy Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of Brain</u> <u>823X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture, comminuted, base of cranium</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>5 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver In Auto in Street, Failed to negotiate Turn.</u>					
20c. TIME OF INJURY Month, Day, Year <u>1:37</u> <u>Apr. 17</u> <u>19 57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Naval Air Sta. Patuxent River, Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart, MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>4-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bellevue, Iowa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u>				24a. REC'D BY REGISTRAR DATE <u>4-17-57</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 22 1967

BUREAU V. S.

4263

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN b 16 hrs. 45 min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hosp. Inc.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney d. STREET ADDRESS Box 13 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Bertha Smith Johnson		4. DATE OF DEATH Month Day Year April 15 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/86
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Franklin Smith		14. MOTHER'S MAIDEN NAME Anna Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 132-16	
17. INFORMANT Arthur Herbert Johnson		Address Box 13 Olney, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4200 DUE TO with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction (c) Arteriosclerosis / Heart Disease 15 yrs		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 15, 1957 , to Apr. 16, 1957 , that I last saw the deceased alive on Apr. 15, 1957 , and that death occurred at 4:45 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Gaithersburg, Maryland ACTUAL SIGNATURE J. Schumacher, M.D. PHYSICIAN'S NAME (Type) J. Schumacher, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 13-11-11		22b. DATE THEREOF Apr. 16 1957	
22c. NAME OF CEMETERY OR CREMATORY 13-11-11		22d. LOCATION (City, town, or county) (State) 13-11-11	
23. FUNERAL DIRECTOR'S SIGNATURE 13-11-11		24a. REC'D BY REGISTRAR 4-16-57	
24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05349

Items 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

CERTIFICATE OF DEATH

Reg. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
c. LENGTH OF STAY IN 1b 7 days		d. STREET ADDRESS Rt. #2, Box 71	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Mitchell Johnson	4. DATE OF DEATH Month April Day 14 Year 1957		
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/77
9. AGE (In years last birthday) 80 yn.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Long		14. MOTHER'S MAIDEN NAME Lucy Jane Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 days 20 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 1940, to April 14 , 1957, that I last saw the deceased alive on April 14 , 1957, and that death occurred at 9:00P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles S. Whitaker, M. D.		M.D.	
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M. D.		Clarksville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 4-17-57	22c. NAME OF CEMETERY OR CREMATORY Hopkins Chapel Cem.	22d. LOCATION (City, town, or county) (State) Highland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE P. C. Hinchbottom, Ellicott City, Md.		24a. REC'D BY REGISTRAR 5-9-57	
		24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler	

BUREAU V. B.

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01247

4265

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 74 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 691 Chinles Drive			
3. NAME OF DECEASED (Type or print) First Margie Middle Ann Last JOHNSON				4. DATE OF DEATH Month April Day 1 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 Sept. 1931		9. AGE (In years last birthday) 25 yrs		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Mc Culley				14. MOTHER'S MAIDEN NAME Hazel Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Husband, Curtis M. Johnson, Jr. (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Hodgkins Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 5 p. m. Month, Day, Year 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 Jan. 19 57 , to 1 April 19 57 , that I last saw the deceased alive on 1 April 19 57 , and that death occurred at 3:12 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. S. Dunn Jr.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 4-2-57					
PHYSICIAN'S NAME (Type) T. S. DUNN, JR. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 4-5-57		22c. NAME OF CEMETERY OR CREMATORY Cross Roads Cemetery		22d. LOCATION (City, town, or county) (State) Carlton, Alabama	
23. FUNERAL DIRECTOR'S SIGNATURE A. K. Humphrey				24a. REC'D BY REGISTRAR 4-2-57		24b. REGISTRAR'S SIGNATURE May E. Parrelly	

BUREAU V. S.

APR 4 1907

RECEIVED

4266

CERTIFICATE OF DEATH

Reg. Dist. No. 225

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>3210 13th, S.E. Apt. #2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>Robert</u> Last <u>JUERGENSEN</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>22 April 1957</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Arthur Peter Juergensen</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Rochester</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>(Father) Arthur P. Juergensen (Same As #2)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGENITAL ATELECTASIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>0</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>INDEFINITE</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>22 April</u> , 19 <u>57</u> , to <u>23 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>23 April</u> , 19 <u>57</u> , and that death occurred at <u>1:55 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Daniel Shupstar</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>		4-24-57	
PHYSICIAN'S NAME (Type) <u>Daniel Shupstar, LT, Md, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-26-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. L. Shupstar</u>		24a. REC'D BY REGISTRAR DATE <u>4-24-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary E. Carroll</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

APR 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4267

CERTIFICATE OF DEATH

Reg. Dist. No.

04249
216

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland c. LENGTH OF STAY IN 1b 121 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE New York b. COUNTY Buffalo c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Michigan Avenue d. STREET ADDRESS 52 Michigan Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First John Middle Katilauckas Last Katilauckas		4 DATE OF DEATH Month April Day 4 Year 19 57	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 6, 1882
9 AGE (In years last birthday) 74 yrs		F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b KIND OF BUSINESS OR INDUSTRY Maritime Service	11 BIRTHPLACE (State or foreign country) Lithuania
12 C ITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Unknown	
14 MOTHER'S MAIDEN NAME Eva Katilauckas		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No	
16 SOCIAL SECURITY NO 294-03-0275		17 INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of larynx DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 wk 9 mos		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cellulitis of skin; Salmonella C. enteritidis	
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) Bethesda 14, Maryland		(County) (State)	
21. I certify that I attended the deceased from December 4, 19 56 to April 4, 19 57 , that I last saw the deceased alive on April 4, 19 57 , and that death occurred at 4:25 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 4/9/57			
ACTUAL SIGNATURE Samuel Charache M.D.		PHYSICIAN'S NAME (Type) Samuel Charache, M.D.	
22a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b DATE THEREOF 4/12/57	
22c NAME OF CEMETERY OR CREMATORY Wash. National		22d LOCATION (City, town or county) (State) Suitland, Md	
23 FUNERAL DIRECTOR'S SIGNATURE W W Chambers Co. ADDRESS Wash, D.C.		24a REC'D BY REGISTRAR APR 11 1957 24b REGISTRAR'S SIGNATURE Bessie Thompson	

1. This certificate is required by law to be filled out by the attending physician and completely filled in by the funeral director. It is to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

APR 11 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NEW YORK b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 6 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3517 Leland Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BINGHAMTON	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle THEODORE Last KETCHUM		4. DATE OF DEATH Month April Day 20 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1901
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Procurement officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick C. Ketchum		14. MOTHER'S MAIDEN NAME Elizabeth Hunt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 107-09-3674	
17. INFORMANT Police records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Barbiturate poisoning (Suicide) DUE TO (b) Found dead in bed DUE TO (c) 11.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 20, 1957	
22a. BURIAL CREMATION, REMOVAL (Specify) TRANS. & BURIAL	22b. DATE THEREOF 4/25/57	22c. NAME OF CEMETERY OR CREMATORY TIOGA CEMETERY	22d. LOCATION (City, town, or county) (State) BINGHAMTON, NEW YORK
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey		24a. REC'D BY REGISTRAR 4-24-57	24b. REGISTRAR'S SIGNATURE Bernie M. Humphrey

THIS DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 25 1957

RECEIVED

4269

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		d. STREET ADDRESS 2310 Connecticut Ave., N.W.	
3. NAME OF DECEASED First Helen Middle Huber Last KILBURN		4. DATE OF DEATH Month April Day 11 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Jan. 1871
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Bartlett J. Cromwell		14. MOTHER'S MAIDEN NAME Lizzie Styles Huber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Niece) Mrs. Elizabeth C. Sypher, (Same As #2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 24 Hrs. unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 April , 19 57 , to 11 April , 19 57 , that I last saw the deceased alive on 11 April , 19 57 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. U. Shilling M.D. U.S. Naval Hospital, Bethesda, Md. 4-12-57			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) C. U. SHILLING, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 16 April 1957	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE James C. Gorman		24a. REC'D BY REGISTRAR 4-12-57	
24b. REGISTRAR'S SIGNATURE James C. Gorman		24c. REGISTRAR'S SIGNATURE James C. Gorman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4270

CERTIFICATE OF DEATH

01252
Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY CO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MONTGOMERY</u>				c. LENGTH OF STAY IN TB <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MONTGOMERY GENERAL CLINIC</u>				d. STREET ADDRESS <u>GAITHERSBURG MD RURAL</u>			
3. NAME OF DECEASED (Type or print) <u>ALBERT</u> First Middle Last <u>KING</u>				4. DATE OF DEATH <u>APRIL</u> Month <u>21</u> Day <u>1957</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CH</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 9 1871</u>	
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>day work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm & Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WILLIAM KING</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-32-1345</u>			
17. INFORMANT <u>Linn King, Father's Sister, 1719</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Constrictive heart failure - Urinary</u> <u>420.0</u> DUE TO <u>Atherosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Yes</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Inguinal Hernia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/13</u> , 19 <u>57</u> , to <u>4/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/21</u> , 19 <u>57</u> , and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>				DATE SIGNED <u>4/21/57</u>			
PHYSICIAN'S NAME (Type) <u>C. H. LIGON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BROOK GROVE</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Paysonville Md</u>				24. REC'D BY REGISTRAR <u>[Signature]</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04253

4271

CERTIFICATE OF DEATH

Reg. Dist. No. 516

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 3 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D. C. 47	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				d. STREET ADDRESS 2009 EYE STREET, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JACK (nmi) EUGENE (also known as Jack Eugene Kruppenbacher)				4. DATE OF DEATH Month Day Year APRIL 16 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 29, 1901	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FISCAL ACCOUNTING CLERK				10b. KIND OF BUSINESS OR INDUSTRY U. S. TREASURY		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME JOSEPH KRUPPENBACHER				14. MOTHER'S MAIDEN NAME KATHERINE REINHARDT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 111-03-4533		17. INFORMANT Address RD. MRS. JOHN W. MILLER, 9411 WARREN ST., SILVER SPRING,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis left circumflex coronary DUE TO (c) Advanced coronary atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rt. hemiplegia from thrombosis left mid. cerebral (8 months)							INTERVAL BETWEEN ONSET AND DEATH 1 days 2 days 7 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November 1956 to April 16 1957 , that I last saw the deceased alive on April 16 1957 , and that death occurred at 2:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 931 Pershing Drive Silver Spring, Maryland DATE SIGNED 4/16/57							
ACTUAL SIGNATURE Jason Geiger				M.D. 931 Pershing Drive			
PHYSICIAN'S NAME (Type) JASON GEIGER				Silver Spring, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 20, 1957		22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Forest Glen, Montgomery Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey				ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE 4-22-57	
				24b. REGISTRAR'S SIGNATURE B. W. M. Humphrey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 24 1957

BUREAU V. E.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4272 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 042544

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b Since 1948 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2603 Arvin Street		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING d. STREET ADDRESS 2603 Arvin Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle H. Last LANGEN		4. DATE OF DEATH Month APRIL Day 22 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 7, 1903
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICAL ENGINEER - Navy Dept.		10b. KIND OF BUSINESS OR INDUSTRY New Jersey	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henry Langen		14. MOTHER'S MAIDEN NAME Betha Hinte	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 101-05-8944	
17. INFORMANT Mrs. Anne Del'Orme Langen, 2603 Arvin St.		Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage and laceration 976X DUE TO bullet wound in skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Sudden DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) Self inflicted bullet wound in right temple	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 6:00 a.m. 4/22 1957		20d. INJURY OCCURRED Where at work <input type="checkbox"/> Not where at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Silver Spring, Montgomery, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) FRANK J. BROSCHART		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 4/22/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 4/24/57	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE 4/25/57		24b. REGISTRAR'S SIGNATURE Frances Satter	

BUREAU V. S.

1957 09 09

RECEIVED

4273

CERTIFICATE OF DEATH

04255

Reg. Dist. No. 276

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
c. LENGTH OF STAY IN 1b 42 hours				d. STREET ADDRESS 7213 Chestnut Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Hixson Last Larkin				4. DATE OF DEATH Month 4 Day 26 Year 1957			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-69		9. AGE (In years last birthday) 88 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Government Print.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Hixson				14. MOTHER'S MAIDEN NAME Harriett Hickerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None		17. INFORMANT George Larkin (son) Address Cincinnati, Ohio			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Confluent Bilateral Bronchopneumonia - DUE TO (b) Pneumonia - DUE TO (c) Chronic congestive Myocardial Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH 3 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular disease						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1955 to April 26, 1957 that I last saw the deceased alive on April 25, 1957 , and that death occurred at 8:20 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Stewart Clapp M.D.				3921 Ingomar St 4-26-57			
PHYSICIAN'S NAME (Type) Stewart Clapp				Wash 15-D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/57		22c. NAME OF CEMETERY OR CREMATORY Manassas		22d. LOCATION (City, town, or county) (State) Manassas, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR 4-26-57		24b. REGISTRAR'S SIGNATURE Beauregard Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 29 1957

RECEIVED

4179

CERTIFICATE OF DEATH

Reg. Dist. No.

770

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ----- b. COUNTY -----			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District of Columbia			
d. STREET ADDRESS 5003 14th Street N. W.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Brandt Last Latimer				4. DATE OF DEATH Month April Day 2 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-24-83	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor--Retired		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME William Latimer			
14. MOTHER'S MAIDEN NAME Mary Beasant		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage of duodenal ulcer 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (Exsanguination) (c) -----		INTERVAL BETWEEN ONSET AND DEATH Terminal		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 to April 2 , 1957, that I last saw the deceased alive on April 1 , 1957, and that death occurred at 4:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Takoma Park, Md. DATE SIGNED 4/2/57							
ACTUAL SIGNATURE Robert A. Hare		M.D. Takoma Park, Md.		DATE SIGNED 4/2/57			
PRINTED NAME (Type) Robert A. Hare							
22a. BURIAL, CREMATION, REINTERMENT (Specify) 4-2-57		22b. DATE THEREOF 4-2-57		22c. NAME OF CEMETERY OR CREMATORY Lee's Chapel - Wash. D.C.		22d. LOCATION (City, town, or county) (State) Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. L. London's Co. 300 4th St. N.E. Wash. D.C.		ADDRESS 300 4th St. N.E. Wash. D.C.		24a. REC'D BY REGISTRAR APR 4 1957		24b. REGISTRAR'S SIGNATURE J. H. Hare	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01257

4274

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. STREET ADDRESS <i>2803-Sheaton Sh.</i>	
3. NAME OF DECEASED (Type or print) <i>Steve Edwards</i> First Middle Last		4. DATE OF DEATH <i>April 14 1957</i> Month Day Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 14, 1957</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baker</i>	11. BIRTH PLACE (State or foreign country) <i>Virginia</i>
13. FATHER'S NAME <i>Chris Lawson</i>		14. MOTHER'S MAIDEN NAME <i>Patricia Tully</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Chris Lawson-Item# 2</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Peritonitis</i> DUE TO <i>Intestinal Obstruction, perforated Aulus</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Congenital Malformation</i> (b) <i></i> (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April 14, 1957</i> , to <i>April 14, 1957</i> , that I last saw the deceased alive on <i>April 14, 1957</i> , and that death occurred at <i>10:20 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George Maxwell</i> M.D. <i>121 S. Washington St. Rockville, Md.</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Dr. George Maxwell</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/17/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>	22d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>		24a. REC'D BY REGISTRAR <i>4-15-57</i>	24b. REGISTRAR'S SIGNATURE <i>W. H. Thompson</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 17 1957
BUREAU V. S.

4275

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria 83X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>2959 Sycamore Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Patrick</u> Middle <u>James</u> Last <u>LEONARD</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 February 1957</u>	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months <u>2</u> Days <u>15</u>	IF UNDER 24 HRS Hours <u>15</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Warren E. Leonard</u>				14. MOTHER'S MAIDEN NAME <u>Johnny Louise Cummins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>(Father) Warren E. Leonard (Same As #2)</u>			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intestinal pneumonia</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital heart disease</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>9 April</u> 19 <u>57</u> , to <u>16 April</u> 19 <u>57</u> , that I last saw the deceased alive on <u>16 April</u> 19 <u>57</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>4-17-57</u>							
ACTUAL SIGNATURE: <u>Howard A. Pearson</u> M.D.		U.S. Naval Hospital, Bethesda, Md.					
PHYSICIAN'S NAME (Type) <u>Howard A. Pearson, LT, MC, USN</u>		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-19-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Ashby</u> <u>R. A. Ashby, 7551 Wisconsin Ave., Bethesda, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>4-17-57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary E. Gandy</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

042514
214

4276

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>24 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3704 Jeffry St.</u>				d. STREET ADDRESS <u>3704 Jeffry St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Levy</u> Last <u>Levy</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-18-88</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>6</u> Min. <u>4</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>Lewis Levy</u>				14. MOTHER'S M maiden NAME <u>Rachel Greenbaum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Ruth Greenbaum Same as Item 2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4:00.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE <u>4-2-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/7/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Israel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Dedham Mass</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Kaugansky & Sons</u>				ADDRESS <u>3501 14th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>4/4/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Fancee Potter</u>							

MEDICAL CERTIFICATION

THIS DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
APR 8 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. *216*

04260

4277

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Michigan</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Detroit</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				d. STREET ADDRESS <i>19366 Indianapolis</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>ANNA</i> Middle <i>K.</i> Last <i>LEWIS</i>				4. DATE OF DEATH Month <i>4</i> Day <i>24</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-10-79</i>	
9. AGE (In years last birthday) <i>77</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Michigan</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				13. FATHER'S NAME <i>MOSES KALVER</i>			
14. MOTHER'S MAIDEN NAME <i>ETTA WINSBERG</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <i>Daughter</i> <i>Charles H. Lewis</i> Address <i>Detroit, Michigan</i> <i>19366 Indianapolis</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute fulminant coronary</i> DUE TO <i>congestive heart failure</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i> <i>5 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>X</i> <i>diabetes mellitus</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <i>April 22, 1957</i> to <i>April 24, 1957</i> , that I last saw the deceased alive on <i>April 24, 1957</i> , and that death occurred at <i>3:10</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert H. Coale</i>				M.D. <i>4630 Montgomerystown, Bethesda, Md</i> DATE SIGNED <i>4/24/57</i>			
PHYSICIAN'S NAME (Type) <i>ROBERT N. COALE</i> M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>APRIL 26, 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>GRANDVIEW</i>		22d. LOCATION (City, town, or county) (State) <i>JOHNSTOWN P. A.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Dargatzakytson</i>				ADDRESS <i>3501-14th St NW</i>		24a. REC'D BY REGISTRAR <i>DATE 4-29-57</i>	
24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>							

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

APR 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04261 214
Reg. Dist. No.

4278

File 14 File 23 4-12-57 et.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>not DC.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 4 in 3</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>318 Tench. Ave. N.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9108 Crosby Rd.</u>		e. IS RES. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna Catherine Linsenmeyer</u>		4. DATE OF DEATH <u>Apr 6 1957</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 8 1875</u>	
9. AGE (In years last birthday) <u>81 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Donohue</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Grace Mallon (daughter) Same as #1</u>	
17. INFORMANT <u>Grace Mallon (daughter) Same as #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-6-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 10, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.W. Lee-Bon</u>		ADDRESS <u>Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>APR 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 7 1964

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04262

214

4279

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>8 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2101 Hildarose Dr</u>				d. STREET ADDRESS <u>2101 Hildarose Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Field</u> Last <u>Lloyd</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-1890</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Borzellai Field</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Kimball</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Name <u>Bernard L. Lloyd (husband)</u> Address <u>Same Street 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	Month, Day, Year <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Trans. & Burial</u>		<u>4/22/57</u>		<u>Melrose Cemetery</u>		<u>Brockton, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warren E. Humphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4-20-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>James J. Feller</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 48 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4280 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 042635

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 14/17</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>6907 Prince Georges Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sara</u> Middle <u>Ann</u> Last <u>Lord</u>				4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 4, 1936</u>	
9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At U. of M.</u>		11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John L. Lord</u>				14. MOTHER'S MAIDEN NAME <u>Jesse m. Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mr. John L. Lord</u>		Address <u>Takoma Park, Md.</u> <u>6907 Prince Georges Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>Compression & crushing left chest</u> DUE TO (c) <u>Auto accident (compression between auto and bank)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>fracture pelvis & cervical vertebra</u>						INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was passenger in car involved in auto accident</u>					
20c. TIME OF INJURY Month, Day, Year <u>12:05 p.m. 4/23/57</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>River Rd.</u>		20f. (City or town) (County) (State) <u>Glen Echo Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/23/57</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 26, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank J. Broschart</u>				ADDRESS <u>2514 CARROLL ST. N.E. Wash., D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>4/25/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>May Parrelly</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. M.

1957

ED V

CERTIFICATE OF DEATH

Reg. Dist. No.

01264

214

4281

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unity			c. LENGTH OF STAY IN TB life		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. STREET ADDRESS 1		
3. NAME OF DECEASED (Type or print) First William Middle Luckett Last Luckett			4. DATE OF DEATH Month April Day 29 Year 19 57		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 17, 1888	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Elijah Gilmore			14. MOTHER'S MAIDEN NAME Mary E. Luckett		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Daniel Gaither 605 Stonestreet, Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiorenal Disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 16, 1936 to 4/29/57 , 19 57 , that I last saw the deceased alive on 4/29/57 , 19 57 and that death occurred at 4:45 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Webster Sewell		M.D. Webster Sewell		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Webster Sewell		Rt. Belmont Spring			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/3/57	22c. NAME OF CEMETERY OR CREMATORY Arlington		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Rokut L. Snowden		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR May 7 1957	24b. REGISTRAR'S SIGNATURE Frances Potter

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 2 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04265

4282

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westmoreland Hills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westmoreland Hills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5108 Duvall Drive		d. STREET ADDRESS 5108 Duvall Drive • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Eleanora Luve		4. DATE OF DEATH Month Day Year April 4, 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/1873
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel Lee		14. MOTHER'S MAIDEN NAME Julia Ann Trodden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - -		16. SOCIAL SECURITY NO - - -	
17. INFORMANT Mrs. Marton		Address 5108 Duvall Drive, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ARTERY Thrombosis 392X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) Arteriosclerosis, General and Cerebral 10 YRS DUE TO (c) 10 YRS INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus; Gangrene Right Foot			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1957 , to May 4, 1957 , that I last saw the deceased alive on April 4, 1957 , and that death occurred at 4:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1155 - ... 3/4/57			
ACTUAL SIGNATURE Frank S. Bacon		M.D. 1155 - ...	
PHYSICIAN'S NAME (Type) Frank S. Bacon			
22a. BURIAL-CREMAATION-REMOVAL (Specify)		22b. DATE THEREOF 4/6/57	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co., 2901 14th St. Wash		ADDRESS D.C.	
24a. REC'D BY REGISTRAR DATE 4-6-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

APR 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04266

Reg. Dist. No.

217

4283

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Fairland			c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Off Fairland- Beltsville Rd.				d. STREET ADDRESS 12903 Parkland Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Leo Francis Mangan <div style="text-align: center;">First Middle Last</div>				4. DATE OF DEATH <div style="text-align: center;">Month Day Year</div> April 2 1957 19				
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/4/15		9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11 BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME George P. Mangan				14. MOTHER'S MAIDEN NAME Rose Melling				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, no, or dates of service)		17. INFORMANT Police Records			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: cerebral hemorrhage 976x IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) bullet wound in rt. skull DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bending							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Shot self with 22 ca. rifle while in car						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 4/1/57 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) woods		20f. (City or town) nr Fairland		(County) Montg (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, (inspection <input checked="" type="checkbox"/>, inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.								
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4/2/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/57	22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank Geiers Sons Co</i>				ADDRESS 3605-14 ST NW		24a. REC'D BY REGISTRAR- (Date) APR 3 1957		24b. REGISTRAR'S SIGNATURE <i>Bertrude Lawley</i>

THIS DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. B.

APR 3

RECEIVED

4180

CERTIFICATE OF DEATH

Reg. Dist. No.

01267

7/13

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b II Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE New Jersey b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jersey City c. STREET ADDRESS 2540 Hudson Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elsie Middle (MAM) Last Margolis				4. DATE OF DEATH Month April Day 26 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-8-97	
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min 0		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? America	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher (Retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Henry Alback				14. MOTHER'S MAIDEN NAME Otilla Mohr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lips - filus - sarcoma 197X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/14/57 , 19____, to 4/26/57 , 19____, that I last saw the deceased alive on 4/26/57 , 19____, and that death occurred at 325A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Raymond C. Weiss M.D.				DATE SIGNED Wash. Sanit.			
NOTICE: NAME (Type)							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-26-57		22c. NAME OF CEMETERY OR CREMATORY Jersey City Cem		22d. LOCATION (City, town, or county) (State) Jersey City N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Deal				ADDRESS 4812 Georgia Ave NW		24a. REC'D BY REGISTRAR APR 30 1957	
				24b. REGISTRAR'S SIGNATURE John H. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

APR 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04268

Reg. Dist. No. 218

4284

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Gaithersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>106 N. Frederick Ave.</u>				d. STREET ADDRESS <u>106 N. Frederick Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Janet Sue Marsee</u>				4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/28/1957</u>		9. AGE (In years last birthday) yrs. <u>26</u>	IF UNDER 1 YEAR Months <u>26</u>	IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bill Marsee</u>				14. MOTHER'S MAIDEN NAME <u>Verda Fitts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother Same as Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to vomitus</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> 19 </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				<u>4/24/57</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Willesboro Cemetery in Johns Hopkins</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u>				ADDRESS <u>Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4-26-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Verda G. Cook</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 30 1957

BUREAU V. 2

4181

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN TB <i>7 weeks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Evelyn</i> Middle <i>Evangelina</i> Last <i>McCalley</i>		4. DATE OF DEATH Month <i>4</i> Day <i>3</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OF RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-17-82</i> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Va.</i>	
11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Presley Balderson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Coates</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Washington Sanitarium & Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive heart failure</i> DUE TO <i>Infarct of the myocardium</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>260X</i> DUE TO <i>Diabetes mellitus + Recurrent bilateral pneumonia</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <i>Several months</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1950</i> , 19 <i>April 3</i> , 19 <i>57</i> to <i>April 3</i> , 19 <i>57</i> that I last saw the deceased alive on <i>April 3</i> , 19 <i>57</i> , and that death occurred at <i>2:21</i> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>9210 Columbia Rd, Silver Spring Md</i> DATE SIGNED <i>4/3/57</i>			
ACTUAL SIGNATURE <i>Sydney Leventhal</i>		PHYSICIAN'S NAME (Type) <i>SYDNEY LEVENTHAL</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>April 6, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Montgomery County Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>S. Brothers & Sons</i>		ADDRESS <i>254 Carroll Rd. NW. W.C.</i>	
24. REC'D BY REGISTRAR <i>485-1097</i>		25. REGISTRAR'S SIGNATURE <i>John A. Hall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. R.

APR 8 1957

151

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4285 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04270

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b 2 1/2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10,021 RENFREW ROAD				d. STREET ADDRESS 10,015 RENFREW ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First KIM Middle EDWARD Last McCARREN				4. DATE OF DEATH Month APRIL Day 18 Year 1957				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 14, 1950		
9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months 7 Days 18		IF UNDER 24 HRS. Hours 18 Min. 15				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT			10b. KIND OF BUSINESS OR INDUSTRY SCHOOL		11. BIRTHPLACE (State or foreign country) BOSTON, MASS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN F. McCARREN				14. MOTHER'S MAIDEN NAME DOLORES J. JASPER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mr. John F. McCarren, 10,015 Renfrew Rd.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) accidental head and neck injury (c) stroke injury DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silver Spring, Md. INTERVAL BETWEEN ONSET AND DEATH 5 min.								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> Struck left upper neck by baseball while playing				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year 3:30 April 18 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Silver Spring, Montgomery, Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) FRANK J. BROSCART				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
DATE SIGNED 4/19/57								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/20/57		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND		
23. FUNERAL DIRECTOR'S SIGNATURE Warner & Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 4/19/57		
				24b. REGISTRAR'S SIGNATURE Frances				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 20 1957

BUREAU V. S.

4182

CERTIFICATE OF DEATH

Reg. Dist. No. 223

04271

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington DC</u> b. COUNTY <u>DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1111 Pennsylvania Avenue</u>				d. STREET ADDRESS <u>310 - 2nd St NE</u>			
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>AGNES</u> Last <u>MC CREADY</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-8-1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret U.S. Post</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>William H. McCreedy</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth F. Leasty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>E. R. Nelson</u> Address <u>Wash D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia + hemorrhage</u> DUE TO <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of Colon</u> DUE TO (c) <u>Cancer of Colon</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 days</u> <u>6 mos.</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Oct 9</u> , 1957, to <u>Apr 24</u> , 1957, that I last saw the deceased alive on <u>Apr 23</u> , 1957, and that death occurred at <u>3:57 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. S. Crisp</u>				ADDRESS (Street, city or town, state) <u>501 - 8th St NE</u>			
PHYSICIAN'S NAME (Type) <u>E. S. Crisp, MD</u>				DATE SIGNED <u>Apr 24/1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4-25-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Franklin Cem. Washington - DC</u>		22d. LOCATION (City, town, or county) (State) <u>DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee</u> ADDRESS <u>Wash D.C.</u>				24a. REC'D BY REGISTRAR <u>J. Wilson Dodd</u> DATE <u>4/26/57</u>		24b. REGISTRAR'S SIGNATURE	

1. **HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

2. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

APR 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04272

4286

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6313 Broad Branch Rd.				d. STREET ADDRESS 6313 Broad Branch Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Galbraith Last McGraw				4. DATE OF DEATH Month Apr. Day 13, Year 1957 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/5/1888		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 5 Days 3 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Auto Mechanic		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nicholas McGraw				14. MOTHER'S MAIDEN NAME Ellen Hayes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.1 577-20-0687		17. INFORMANT Address Helen Herzog(sister) Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank U. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial-transit		4-15-57		St. James Church Cem.		Naugatuck, Conn.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 4-15-57	
				24b. REGISTRAR'S SIGNATURE Deane W. Herzog			

MEDICAL CERTIFICATION

TO THE MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. Burial, cremation, or removal.

BUREAU V. S.

APR 17 1957

RECEIVED

MDARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18 4287 CERTIFICATE OF DEATH

04273

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie McPhee		4. DATE OF DEATH Apr 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 23-1866 101 years
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
13. FATHER'S NAME James McCoy		14. MOTHER'S MAIDEN NAME Elizabeth Rosenb. rry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT The Marylander-Records, Germantown, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 17, 1955 to April 12, 1957 , that I last saw the deceased alive on April 9, 1957 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, state) Thomasboro, Md.	
PHYSICIAN'S NAME (Type) James P. Kerr		DATE SIGNED 4/13/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-15-57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Washington, Suitland, Md
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner		ADDRESS Walthersburg, Md.	
24a. REC'D BY REGISTRAR Apr 16-57		24b. REGISTRAR'S SIGNATURE Abraham G. Cooke	

RECEIVED

APR 22 1957

BUREAU V. S.

4288

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 5 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1010 Quebec Terrace				d STREET ADDRESS 142 Moredale Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First ANNA Middle A. Last METTING		4 DATE OF DEATH Month APRIL Day 25 Year 1957					
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH JAN. 4, 1896	9 AGE (In years last birthday) 61 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - OWN HOME		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME JOHN J. GALLAGHER				14. MOTHER'S MAIDEN NAME EMMA A. FROEHLICH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO NONE		17. INFORMANT Address Mr. Wm. E. Metting, 1010 Quebec Terrace, Apt. 103 Silver Spring, Maryland			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Massive Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Coronary Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH immediate							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 21, 1956, to April 25, 1957, that I last saw the deceased alive on April 24, 1957, and that death occurred at 8:10 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Dean H. Harding		M.D. 113 Carroll St NW		ADDRESS (Street, city or town, state) 113 Carroll Street, N. W., Washington L. J.		DATE SIGNED 4/26/57	
PHYSICIAN'S NAME (Type) Dean H. Harding, M. D.		22a. NAME OF CEMETERY OR CREMATORY ZIMMERMANN CEMETERY		22a LOCATION (City, town, or county) PITTSBURGH, PENNSYLVANIA		(State)	
22b. DATE THEREOF 4/26/57		23. FUNERAL DIRECTOR'S SIGNATURE Wm. E. Humphrey		24a REC'D BY REGISTRAR DATE 4/29/57		24b. REGISTRAR'S SIGNATURE Francis Potter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Broschart was notified by telephone
and he stated he would approve
Dean H. Harding

BUREAU V. F.

APR 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4289 **CERTIFICATE OF DEATH**

01275
217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>6 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>4504 Burlington Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Cecile</u> Last <u>Michael</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 20 - 1897</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>4</u> Hours <u>4</u> Min <u></u>		IF UNDER 24 HRS. Hours <u></u> Min <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Frederick, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Clayton M. Zimmerman</u>				14. MOTHER'S MAIDEN NAME <u>Myra Beatty</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give no. of unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Myron Michael - Husband</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>DEBILITY - MALICE OF LEFT</u> DUE TO (b) <u>PAROTID GLAND = METAST.</u> DUE TO (c) <u>TO BRAIN</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Oct. 5 - 1956</u> , to <u>Apr. 24 - 1957</u> , that I last saw the deceased alive on <u>April 14 - 1957</u> , and that death occurred at <u>10:58</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>John B. Ziegler</u> M.D.							
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24. RECEIVED BY REGISTRAR <u>APR 25 1957</u>	
25. REGISTRAR'S SIGNATURE <u>Bertranda Lawless</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 20 1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 216

4290

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 40 Minutes			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. STREET ADDRESS 9314 Georgetown Rd.			
3. NAME OF DECEASED (Type or print) First David Middle N Last Miller				4. DATE OF DEATH Month April Day 13 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1882		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS Days 4 Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Clerk-Retired		10b. KIND OF BUSINESS OR INDUSTRY Railway Mail Serv.		11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jones T. Miller				14. MOTHER'S MAIDEN NAME Emma Whitlock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT William J. Miller		Address 9314 Georgetown Rd., Beth. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Mitral Disease, Stenosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis Coronary						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from Aug. 19 54 , to date 19____, that I last saw the deceased alive on 13 April 19 57 , and that death occurred at 2:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED Apr. 13, 1957							
ACTUAL SIGNATURE John G. Ball M.D.				PHYSICIAN'S NAME (Type) JOHN G. BALL MM 7936 Old Georgetown Rd. Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-57		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.				24a. REC'D BY REGISTRAR 4-15-57		24b. REGISTRAR'S SIGNATURE Barbara M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 17 1917

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

042273

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Seniors Hosp</u>		d. STREET ADDRESS <u>14 Sherman Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>Medley</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1957</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-27-79</u> 77 yrs
9. AGE (In years last birthday) <u>77</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>7</u> Days <u>27</u> Hours <u>19</u> Min <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hatchery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hatchery</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Moore</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Chart (W.S.H.)</u>	
17. INFORMANT <u>Chart (W.S.H.)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emaciation</u> DUE TO (b) <u>Osteomyelitis - Chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Hips</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteogenic Sarcoma at site of Old Osteo</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/18/57</u> to <u>4/19/57</u> , that I last saw the deceased alive on <u>4/18/57</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard T. Morse</u> M.D.		ADDRESS (Street, city or town, state) <u>7030 Carroll Ave</u> DATE SIGNED <u>4/19/57</u>	
PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>		ADDRESS <u>Takoma Park Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 22-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Garton</u>		ADDRESS <u>Gaithersburg, Md.</u>	
24. RECEIVED BY REGISTRAR <u>APR 23 1957</u>		25. REGISTRAR'S SIGNATURE <u>J. Wilson Dolly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 24 1957

BUREAU V. S.

4291

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 50 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4725 Cumberland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle R Last MOORE		4. DATE OF DEATH Month April Day 18 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1872
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months 7 Days 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Waynesville, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Everett Roberts		14. MOTHER'S MAIDEN NAME Sarah Kellen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Margaretta Vogt-4303 Curtis Rd. Chevy Ch. Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Congenitive Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery Disease (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 4 hours 4 years 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1957 to April 18, 1957 , that I last saw the deceased alive on 12:30 PM 4-18-57 , and that death occurred at 4:10 PM M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Vernon S. Martens M.D.		ADDRESS (Street, city or town, state) Germantown, Maryland DATE SIGNED 4-18-57	
PHYSICIAN'S NAME (Type) Vernon S. Martens, M.D.		Germantown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		22b. DATE THEREOF 4/19/57	
22c. NAME OF CEMETERY OR CREMATORY Miami Cemetery		22d. LOCATION (City, town, or county) (State) Waynesville Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		24a. REC'D BY REGISTRAR DATE 4-22-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MEDICAL CERTIFICATION

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 24 1957
BUREAU V. E.

4292

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>Washington, D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kesner Sanitarium 5221 Shawenon Lane Bethesda</u>				d. STREET ADDRESS <u>321 Farragut, St. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Jake</u> First <u>Hyman</u> Middle <u>Mossman</u> Last				4. DATE OF DEATH <u>April</u> Month <u>22</u> Day <u>1957</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 28, 1893</u>	
9. AGE (In years last birthday) <u>64</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>unknown - Benjamin</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>77-44-0962</u>			
17. INFORMANT <u>wife</u> Address <u>321 Farragut, St., N.W.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>dehydration</u>				INTERVAL BETWEEN ONSET AND DEATH			
154X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) <u>Carcinomatosis</u>			
				(c) <u>carcinoma of rectum</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 2</u> , 19 <u>57</u> , to <u>April 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 20</u> , 19 <u>57</u> , and that death occurred at <u>11:45 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>4261 A Pottery Lane, Bethesda, Md.</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Wilfred R. Chementant</u> M.D.				PHYSICIAN'S NAME (Type) <u>4261 A Pottery Lane, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Natl Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u> ADDRESS <u>4217-9th St N.W. D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE 4-25-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED

APR 29 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4293

CERTIFICATE OF DEATH

Reg. Dist. No.

04280

218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD 1, Derwood</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD 1, Derwood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Russell Nursing Home</u>				d. STREET ADDRESS <u>RD 1, Derwood</u>			
3. NAME OF DECEASED (Type or print) <u>EFFIE</u> ^{First} <u>V.</u> ^{Middle} <u>NELSON</u> ^{Last}				4. DATE OF DEATH <u>April</u> ^{Month} <u>23</u> ^{Day} <u>1957</u> ^{Year}			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 17, 1901</u>	
9. AGE (In years, last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Frank Dorsey</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Brooks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Mary J. Prather</u>		Address <u>Derwood, Md. R. F. D. # 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) <u>Arteriosclerotic</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis, ankylosed spine</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-10</u> , 19 <u>56</u> , to <u>4-23</u> , 19 <u>57</u> that I last saw the deceased alive on <u>4-23-57</u> , 19 <u>57</u> , and that death occurred at <u>5:00</u> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clive E. Jackson</u> M.D.				ADDRESS (Street, city or town, state) <u>RD 1, Gaithersburg, Md.</u> DATE SIGNED <u>4-23-57</u>			
PHYSICIAN'S NAME (Type) <u>Clive E. Jackson, M. D.</u>				RD 1, Gaithersburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove,</u>		22d. LOCATION (City, town, or county) (State) <u>Emory Grove, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sworde</u> ADDRESS <u>Rockville, Md.</u>				24. REC'D BY REGISTRAR <u>APR 25 1957</u> DATE		25. REGISTRAR'S SIGNATURE <u>Alfred G. Cook</u>	

1 2 3 4 5

6 7 8 9 10

11 12 13 14 15

BUREAU V. S.

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04281

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.			d. STREET ADDRESS 706 Jefferson Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Danial Middle Shirley Last Nichols			4. DATE OF DEATH Month Apr. Day 5 Year 1957		
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1894	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Druggist		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Va.	
13. FATHER'S NAME Danial H. Nichols			14. MOTHER'S MAIDEN NAME Shirley McFaden		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Rita Nichols(wife) Same as Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic & Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed chest & Fracture of Skull (c) Crushed chest & Fracture of Skull PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 11/11/57
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ran thru stop sign and struck by another car			
20c. TIME OF INJURY Month, Day, Year 11.00 a.m. 4/5/57 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street	20f. (City or town) Bethesda	(County) Montg.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/5/57	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 8/57	22c. NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery		22d. LOCATION (City, town, or county) (State) Charlestown, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR 4-8-57
			24b. REGISTRAR'S SIGNATURE <i>Bessie M. Thompson</i>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. B.

APR 9 1957

RECEIVED

4184
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Pz</u> b. COUNTY <u>Levittown</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>9 days.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mr. Karl Alfons Nordvall</u>				4. DATE OF DEATH <u>April 17 1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-04</u>	9. AGE (in years last birthday) <u>52</u> yrs	10. IF UNDER 1 YEAR		10. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Finland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Karl Nordvall</u>				14. MOTHER'S MAIDEN NAME <u>Emelina J. Lander</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>wife</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Increased intracranial pressure</u> 6 mo.							
20-1X DUE TO (b) <u>Brain tumor (cerebellar)</u> 1 year.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>4-11</u> 1957, to <u>4-17</u> 1957, that I last saw the deceased alive on <u>4-17</u> 1957, and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Harvey H. Ammerman, M.D.</u>				<u>2025-I. R.B.N.U.</u> <u>4-17-57</u>			
PHYSICIAN'S NAME (Type) <u>HARVEY H. AMMERMAN, M.D.</u>				<u>WASH. G. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>APR. 19, '57</u>		<u>GEORGE WASHINGTON CEM.</u>		<u>PIGGS RD. HYATTSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>WASH 12, D.C.</u> DATE <u>APR 19 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

APR 22 1957

RECEIVED

4185

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park - Wash. D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hospital</u>		d. STREET ADDRESS <u>6926 Willow St N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Elizabeth</u> Last <u>OXLEY</u>		4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-30-65</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OHIO</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALFRED OXLEY</u>		14. MOTHER'S MAIDEN NAME <u>Mary King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>friend -</u>	
17. INFORMANT <u>friend -</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Pneumonia</u> DUE TO <u>Heart Bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4/7/57</u> <u>4/10/57</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Infarction</u> <u>4 days</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home; farm; factory, street, office bldg., etc.) <u> </u>
20f. (City or town) <u> </u>		(County) (State)	
21. I certify that I attended the deceased from <u>Mar 5, 1957</u> to <u>Apr 28, 1957</u> that I last saw the deceased alive on <u>Apr 28, 1957</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. J. Morse</u>		M.D. <u>703 Carroll Ave</u>	
PHYSICIAN'S NAME (Type) <u>H. J. Morse</u>		<u>Takoma Park Ind.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 3, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BETHESDA</u> <u>M.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Talley</u>		24. REC'D BY REGISTRAR <u> </u> DATE <u> </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU W. J.

MAY 1 1957

RECEIVED

4186

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Marble Day Hospital</i>		d. STREET ADDRESS <i>2050 Carroll Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>M</i> Middle <i>Maudie</i> Last <i>Paden</i>		4. DATE OF DEATH Month <i>Apr</i> Day <i>28</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Oct 13 1867</i>
9. AGE (In years last birthday) <i>89</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		11. BIRTHPLACE (State or foreign country) <i>Paducah City W Va</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>William J. Padon</i>	
14. MOTHER'S MAIDEN NAME <i>McClister</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Chronical. Papers.</i> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dilatation</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i> DUE TO (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Upper Respiratory Infection delays</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/25</i> , 19 <i>57</i> , to <i>4/27</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>4/26</i> , 19 <i>57</i> , and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard T. Morse</i> M.D.		ADDRESS (Street, city or town, state) <i>2030 Carroll Ave</i> DATE SIGNED <i>4/28/57</i>	
PHYSICIAN'S NAME (Type) <i>Howard T. Morse</i>		<i>Takoma Park Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>Apr 30 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>GEORGE WASHINGTON CEM.</i>	22d. LOCATION (City, town, or county) (State) <i>PRINCE GEORGE COUNTY MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William H. Wilson</i>		24. RECEIVED BY REGISTRAR <i>APR 30 1957</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 1 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04285

Reg. Dist. No. 222

4187

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN <u>Takoma Park</u> (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN <u>Silver Spring</u> (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium and Hospital</u>				d. STREET ADDRESS <u>12410 Viers Mill Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carolyn Diane Painter</u>				4. DATE OF DEATH Month Day Year <u>Apr 20 1957</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 31, 1952</u>	9. AGE (in years last birthday) <u>5</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME <u>Harvey Painter</u>				14. MOTHER'S MAIDEN NAME <u>Martha Rowe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Takoma Park</u> <u>Father and Hospital Records.</u> <u>MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, upper lobes of lung, bilat.</u> <u>471X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Congenital defect of I.V. septum of heart & pulmonic stenosis (prior valvulotomy)</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				DATE SIGNED <u>4/20/57</u>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24. REGD BY REGISTRAR <u>Apr 30 1957</u> 24c. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give 1, 2, and 3 1 the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 18. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

RECEIVED

APR 24 1957

BUREAU Y. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4295

CERTIFICATE OF DEATH

04286

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 1 hr. 20 min.</u> c. LENGTH OF STAY IN b. <u>6 heavy to heavy</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6 heavy to heavy</u> d. STREET ADDRESS <u>4600 Drummond Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Kathryn</u> Middle <u>V.</u> Last <u>Batterson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1957</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/8/1874</u>
9 AGE (In years last birthday) <u>83 yrs</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>15</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Adm. Sales Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11 BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HENRY G. Reiter</u>		14. MOTHER'S MAIDEN NAME <u>Kate Reichert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>165-09-2081</u>	
17. INFORMANT <u>Eva Thurston, 4600 Drummond Ave. Ch. Ch. Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular hemorrhage</u> (b) <u>Hypertensive Cerebrovascular Disease</u> (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/15</u>, 19<u>56</u>, to <u>4/23</u>, 19<u>57</u>, that I last saw the deceased alive on <u>4/23</u>, 19<u>57</u>, and that death occurred at <u>11:20 PM</u>, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. L. Marks</u> M.D.		ADDRESS (Street, city or town, state) <u>6306 Wisconsin Ave. Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>I. L. MARKS, M.D.</u>		DATE SIGNED <u>4/24/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>4/27/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Jt. Peace</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>4-25-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 29 1957

BUREAU V. S.

4296

CERTIFICATE OF DEATH

Reg. Dist. No

216

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 29 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Washington	
f. STREET ADDRESS 345 Cedar Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Mary Middle Hazel Last Patton		4. DATE OF DEATH Month April Day 12 Year 19 57	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH February 11, 1898
9 AGE (In years last birthday) 59 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry (Unknown)		14. MOTHER'S MAIDEN NAME Elizabeth Devore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Int. Cerebral Hemorrhage, etc. sub 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Pyelonephritis, left side.			INTERVAL BETWEEN ONSET AND DEATH 4 wks 20 1 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 14 , 19 57 , to April 12 , 19 57 , that I last saw the deceased alive on April 12 , 19 57 , and that death occurred at 11:55 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4-13-57 ACTUAL SIGNATURE R. W. Weiger, M.D. PHYSICIAN'S NAME (Type) Robert W. Weiger, M. D. National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit Burial	22b. DATE THEREOF April 16, 1957	22c. NAME OF CEMETERY OR CREMATORY Mill Creek Cemetery	22d. LOCATION (City, town, or county) (State) Beaver County, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters		24a. REC'D BY REGISTRAR APR 15 1957	24b. REGISTRAR'S SIGNATURE Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

APR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04288-
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old US R-240		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
f. STREET ADDRESS 924 C St., N.E.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robie Middle Last Payne		4. DATE OF DEATH Month 4/21/67 Day Year 19	
5 SEX male	6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/1/1916
9. AGE (In years, months, and days) 50 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Tillman Payne		14. MOTHER'S MAIDEN NAME Hannah Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Pearl Payne		Address 924 C Street, N. E. Wash. D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 823X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Fracture of Skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which left highway	
20c. TIME OF INJURY Hour 11 p.m. Month 4/21/67 Day Year 19	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway	20f. (City or town) (County) (State) Derwood Montg Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 4/21/67	
22a. REMOVAL, CREMATION, OR REMOVAL (Specify) Removal	22b. DATE THEREOF 4/22/67	22c. NAME OF CEMETERY OR CREMATORY Hall Funeral Home	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.	
24. REG'D BY REGISTRAR APR 25 1967		24b. REGISTRAR'S SIGNATURE A. H. Hedrick	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

U. S. 11

APR 20 1957

RECEIVED

4298

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Harry Middle F. Last Pearce		4. DATE OF DEATH Month April Day 5 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1887
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR: Months 8 Days 1 Hours 1 Min 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paint Foreman John Hopkins A.P.L.		10b. KIND OF BUSINESS OR INDUSTRY Damascus, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levi Pearce		14. MOTHER'S MAIDEN NAME Marian Pease Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 214-12-7751	
17. INFORMANT G. Chester Pearce, Damascus, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion of the myocardium with generalized metastases 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 26, 1954 to April 5, 1957 , that I last saw the deceased alive on April 5, 1957 , and that death occurred at 7:00 p.m. from the causes and on the date stated above. ADDRESS (Street, city, or town, state) Damascus, Md. DATE SIGNED 4/8/57			
ACTUAL SIGNATURE James P. Kerr M.D.		PHYSICIAN'S NAME (Type) James P. Kerr	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 8, 1957	22c. NAME OF CEMETERY OR CREMATORY Damascus Meth.	22d. LOCATION (City, town, or county) (State) Damascus Md.
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Moleworth ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR Apr. 8/57	24b. REGISTRAR'S SIGNATURE Della M. Burdette

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 10 1957

BUREAU V

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use at a burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4299

CERTIFICATE OF DEATH

04290

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arden (Arden)</u>				c. LENGTH OF STAY IN 1b <u>2 mos. 25 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>1405 N. Scott St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Martin Albert PENDERGAST</u>				4. DATE OF DEATH Month Day Year <u>April 1 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 Dec. 1902</u>	9. AGE (In years last birthday) <u>54</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Pendergast</u>				14. MOTHER'S MAIDEN NAME <u>Clara Mills</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes 4-22-21 to 7-24 41)</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>(Wife) Mrs. Miriam Pendergast (Same As #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, rectum with</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized metastasis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>6 Jan.</u> , 19 <u>57</u> , to <u>1 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1 April</u> , 19 <u>57</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				U.S. Naval Hospital, Bethesda, Md. 4-2-57			
PHYSICIAN'S NAME (Type) <u>D.P. OSBORNE, CDR, MC, USN</u>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>351 Wisconsin Ave., Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>4-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

RECEIVED

APR 4 1957

BUREAU V. S.

4300

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 1 day				d. STREET ADDRESS 3300 39th Street, N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Augusta Last PETERSON				4. DATE OF DEATH Month April Day 22 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 Feb. 1876	
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR Months 8 Days 1 Hours 1 Min. 1		11. BIRTHPLACE (State or foreign country) Sweeden		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT (Daughter) Rosalie I. Peterson (Same As 12)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, Cerebral X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Infarction, Myocardium, age undetermined							
INTERVAL BETWEEN ONSET AND DEATH 24 hrs.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Rockville, Maryland				20g. (State) Md			
21. I certify that I attended the deceased from 21 April , 19 57 , to 22 April , 19 57 , that I last saw the deceased alive on 22 April , 19 57 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 4-23-57							
ACTUAL SIGNATURE R.G. Williams M.D. U.S. Naval Hospital, Bethesda, Md.							
PHYSICIAN'S NAME (Type) R.G. WILLIAMS, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-57		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. J. Williams				24a. REC'D BY REGISTRAR DATE 4-22-57			
24b. REGISTRAR'S SIGNATURE May E. Carver				ADDRESS 1555 Wisconsin Ave., Bethesda, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

APR 24 1957

RECEIVED

4301

CERTIFICATE OF DEATH

04293
Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>9810 Galtier Schuffert</u>		c. LENGTH OF STAY IN 1b <u>4420</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Maple Lane Nursing Home</u>		d. STREET ADDRESS <u>Poolerville x 2</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>WALLACE</u> Last <u>POOLE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/25/1874</u>
9. AGE (in years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Monty County employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mayland</u>	
11. BIRTHPLACE (State or foreign country) <u>KS</u>		12. CITIZEN OF WHAT COUNTRY? <u>KS</u>	
13. FATHER'S NAME <u>Tom Wallace Poole</u>		14. MOTHER'S MAIDEN NAME <u>Wilda Alnutt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>4740 Brad. Blvd Chevy Chase, Md</u>	
17. INFORMANT <u>Mrs Virginia Wallace</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO (b) <u>CHRONIC MYOCARDITIS</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 14, 1957</u> to <u>April 9, 1957</u> that I last saw the deceased alive on <u>April 9, 1957</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5206 NORWAY DR. April 9, 1957</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Henry M. Lowden</u> M.D.		DATE SIGNED <u>April 9, 1957</u>	
PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u>		<u>CHEVY CHASE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Monocney</u>	22d. LOCATION (City, town, or county) (State) <u>Beallsville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hiller</u>		ADDRESS <u>Barnesville, Md</u>	
24a. REC'D BY REGISTRAR <u>April 11, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Egan</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 12 1957

RECEIVED

4302

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institutional Residence before admission) a. STATE <u>Dist of Col</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> V	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>4534 Harrison St. NW</u>	
3. NAME OF DECEASED (Type or print) <u>Clarence Edward Purcell</u>		4. DATE OF DEATH <u>April 5 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2, 1895</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>1</u> Days <u>3</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Investigator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Acctg.</u>	
11. BIRTHPLACE (State or foreign country) <u>Alexandria, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Purcell</u>		14. MOTHER'S MAIDEN NAME <u>Emma PEED</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-12-2466</u>	
17. INFORMANT <u>Mrs. Mae S. Purcell - Item 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u> <u>13 days</u> <u>5 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1 1957</u> to <u>April 5 1957</u> that I last saw the deceased alive on <u>April 5 1957</u> and that death occurred at <u>3:45 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Roger Kuntz</u>		ADDRESS (Street, city or town, state) <u>3701 Concession Ave. N.W. Wash D.C.</u>	
PHYSICIAN'S NAME (Type) <u>C. Roger Kuntz, M.D.</u>		DATE SIGNED <u>4-5-57</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/9/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Alexandria Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>4-8-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 9 1957

BUREAU V. S.

4303

CERTIFICATE OF DEATH

04294

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS Fawcett Road Route 3	
3. NAME OF DECEASED (Type or print) First Jesse Middle Marvin Last Robertson		4. DATE OF DEATH Month April Day 6 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1889
9. AGE (In years last birthday) yrs 67		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter and		10b. KIND OF BUSINESS OR INDUSTRY Cabinet Maker	
11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Will Tom Robertson		14. MOTHER'S MAIDEN NAME D. George	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (Yes no, or unknown)		16. SOCIAL SECURITY NO. Marguerite L. Robertson	
17. INFORMANT Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Pulmonary Embolism	
(c) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 10 min	
(d) Hypertensive Cardiovascular Disease		3 years	
(e) Generalized Arteriosclerosis		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1955 to April 6, 1957 , that I last saw the deceased alive on April 6, 1957 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 1463-Rhode Island Ave NW		DATE SIGNED 4/6/57	
ACTUAL SIGNATURE William Robert Perkins		M.D. Washington D.C.	
PHYSICIAN'S NAME (Type) William Robert Perkins			
22a. BURIAL CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 4/10/57	22c. NAME OF CEMETERY OR CREMATORY Congressional Cem.	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Jackson Harris		24a. REC'D BY REGISTRAR 5183 Main St N.W.	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 15 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No

216

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE Maryland b COUNTY Prince Georges	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c LENGTH OF STAY IN 1b 89 days	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Thomas Middle Anthony Last Rogato, Jr.		4. DATE OF DEATH Month April Day 6 Year 19 57	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>	8 DATE OF BIRTH June 1, 1947
9 AGE (In years last birthday) 9 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Boy		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (State or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Thomas A. Rogato, Sr.		14 MOTHER'S MAIDEN NAME Blanche Kirby	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? Yes no or unknown No		16 SOCIAL SECURITY NO None	
17 INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal Septicemia 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Lymphatic Leukemia (c) -			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from January 7, 19 57 to April 6, 19 57 , that I last saw the deceased alive on April 6, 19 57 , and that death occurred at 1:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John Laszlo, M.D.		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) John Laszlo, M.D.			
22a BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
Removal	4-10-57	Arlington Nat.	Arlington Va.
23 FUNERAL DIRECTOR'S SIGNATURE J. W. Lee, Son		24a REC'D BY REGISTRAR Wash. D. C. APR 9 1957	
ADDRESS Wash. D. C.		24b REGISTRAR'S SIGNATURE Bessie Thompson	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 9 1957

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04296

4395

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10737 Colesville Road				d. STREET ADDRESS 10737 Colesville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CARRIE First (H) Middle S. Last ROHRBACH		4. DATE OF DEATH Month April Day 23 Year 1957					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1877	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME B. Elihu Harrell				14. MOTHER'S MAIDEN NAME Fannie B. Bradform			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Doris R. Lyons -RFD #3 Box 595X Address Alexandria, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyper-tension Heart disease DUE TO Cholesterol Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Myocardial Infarction				INTERVAL BETWEEN ONSET AND DEATH 5 yrs 5 yrs 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/4/50 , 19 50 , to 4/23 , 19 57 , that I last saw the deceased alive on 4/23 , 19 57 , and that death occurred at 4:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. C. LEONARDO				ADDRESS (Street, city or town, state) 5801-13th St NW, D.C. DATE SIGNED 4/23/57			
PHYSICIAN'S NAME (Type) A. C. LEONARDO							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 26, 1957		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery Wash., D.C.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc. ADDRESS 317 Pa. Ave., SE DC3				24a. REC'D BY REGISTRAR DATE 4/25/57		24b. REGISTRAR'S SIGNATURE Frances Potter	

BUREAU V. S.

1957

RECEIVED

43:16

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Chesterfield	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bon Air	
c. LENGTH OF STAY IN 1b 42 days		d. STREET ADDRESS 8101 Halidan Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Robert Middle Joseph Last Roper, Jr.		4. DATE OF DEATH Month April Day 12 Year 1957	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 4, 1947
9. AGE (In years last birthday) 9 yrs		IF UNDER 1 YEAR Months 11 Days 8 Hours Min 	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.	
11 BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert J. Roper, Sr.		14 MOTHER'S MAIDEN NAME Margaret Jones	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16 SOCIAL SECURITY NO None	
17 INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral Vascular Collapse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Hemorrhagic Diathesis DUE TO (c) Acute Myelogenous Leukemia		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral Pulmonary Edema		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1 , 19 57 , to April 12 , 19 57 , that I last saw the deceased alive on April 12 , 19 57 , and that death occurred at 6:20 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda 14, Maryland DATE SIGNED 4/12/57			
ACTUAL SIGNATURE James R. Jude		M. D. The Clinical Center	
PHYSICIAN'S NAME (Type) James R. Jude, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/16/1957	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		24a. REC'D BY REGISTRAR DATE 4-15 57	
		24b. REGISTRAR'S SIGNATURE <i>James R. Jude</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 12 1961

RECEIVED

4397

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Virginia b. COUNTY Dickenson	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clintwood	
c. LENGTH OF STAY IN 1b 2 months		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lydia Middle Florence Last Rose		4. DATE OF DEATH Month April Day 26 Year 19 57	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1878
9 AGE (In years last birthday) 79 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11 BIRTHPLACE (State or foreign country) Clintwood, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel French		14. MOTHER'S MAIDEN NAME Emeline Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT George Rose, Damascus, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Anterioschertic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 54 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 22, 1957 to April 26, 1957 that I last saw the deceased alive on April 26, 1957 and that death occurred at 5:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, state) Damascus, Md.	
DATE SIGNED April 27, 1957			
PHYSICIAN'S NAME (Type) James P. Kerr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 29, 1957	
22c. NAME OF CEMETERY OR CREMATORY Smithridge		22d. LOCATION (City, town, or county) (State) Stratton, Dickenson Co. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Mobern		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR April 27, 1957		24b. REGISTRAR'S SIGNATURE Wella O. V. Burdette	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 29 1957
BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04299

4188

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b -			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park				d. STREET ADDRESS 7118-Carroll Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 700-Hudson Ave. Takoma Park, Md				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hildegard Middle Ruh Last Ruh				4. DATE OF DEATH Month April Day 4 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/ 1868	
9. AGE (In years last birthday) 88? yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cartographer				10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT W.A. Linthicum-Eig Bldg. Silver Spring, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile Arteriosclerosis, Generalized DUE TO (c) 10-15 years INTERVAL BETWEEN ONSET AND DEATH 60-65 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 1957, to 4 Apr 1957, that I last saw the deceased alive on 2 April 1957, and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7112 Willow Ave Takoma Park DATE SIGNED 4 Apr 1957							
ACTUAL SIGNATURE E. B. QUEEN M.D.				PHYSICIAN'S NAME (Type) Takoma Park			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		4/6/57		Cedar Hill Cemetery		Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co. Washington, D.				ADDRESS		24a. REC'D BY REGISTRAR APR 9 1957	
				24b. REGISTRAR'S SIGNATURE J. H. Hines			

V

BUREAU OF

SEP 9 1957

RECEIVED

4398

CERTIFICATE OF DEATH

04300

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		2 USUAL RESIDENCE (Where deceased lived If institutional, Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton	
d. NAME OF HOSPITAL (If the hospital gives the address, OR INSTITUTION) The Clinical Center National Institutes of Health, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Frances Middle Lulu Last Sayler		4. DATE OF DEATH Month April Day 27 Year 19 57	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 18 December 1916
9. AGE (In years last birthday) 40		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Representative		10b KIND OF BUSINESS OR INDUSTRY Government	
11 BIRTHPLACE (State or foreign country) Montana		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Burton K. Wheeler		14. MOTHER'S MAIDEN NAME Lulu M. White	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16 SOCIAL SECURITY NO 579-26-6550	
17 INFORMANT The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe hypotension - long period of 1 1/2 hr. before death DUE TO Cardiac arrest 2 mly to CNS metastases Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Metastatic breast Ca to brain, lung, mediastinum + liver (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 hr. 16 mos. 8 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from January 27, 19 57 , to April 27, 19 57 , that I last saw the deceased alive on April 27, 19 57 , and that death occurred at 12.35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Peter D. Olch		M. D. The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Peter D. Olch, M.D.			
22a BURIAL, CREMATION, REMOVAL (Specify) Burial	22b DATE THEREOF 4/30/57	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d LOCATION (City, town, or county) (State) Washington D C
23 FUNERAL DIRECTOR'S SIGNATURE Joseph Samois Samois 1756 Pennsylvania Ave Washington, DC		24a. REC'D BY REGISTRAR DATE 5-2-57	24b REGISTRAR'S SIGNATURE Bruce M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 3 1957

BUREAU V. S.

43-99

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 7 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last Schoonover		4. DATE OF DEATH Month Day Year April 2 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/2/57
9. AGE (In years last birthday) 7		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ray Marshall Schoonover		14. MOTHER'S MAIDEN NAME Esther Carolyn Schnee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Record	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis lungs 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 Hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2 April, 1957 , to 2 April, 1957 , that I last saw the deceased alive on 2 April, 1957 , and that death occurred at 3:05 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. B. Ziegler		ADDRESS (Street, city or town, state) Olney, Md.	
PHYSICIAN'S NAME (Type) J. B. Ziegler		DATE SIGNED 2 April 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF April 3	22c. NAME OF CEMETERY OR CREMATORY Laytonsville	22d. LOCATION (City, town, or county) (State) Laytonsville Md
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		24a. REC'D BY REGISTRAR 4-4-57	
ADDRESS Laytonsville, Md		24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM W. F.

APR 11 1977

RECEIVED

4310

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5801 Bent Branch Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CAROL ALTHEA BUSHNELL SCOTT</u>		4. DATE OF DEATH Month Day Year <u>APRIL 16, 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 11, 1916</u>
9. AGE (In years last birthday) yrs. <u>41</u>		IF UNDER 1 YEAR Months Days Hours Min <u>0 3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Trenton, N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William M. Bushnell</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth A. ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Walter K. Scott-Item # 2</u>	
17. INFORMANT <u>Walter K. Scott-Item # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complete Intestinal Obstruction</u> 51X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Abdominal Carcinomatosis</u> DUE TO (c) <u>GASTRIC CARCINOMA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u> <u>5 mo.</u> <u>7 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 16, 1957</u> to <u>April 16, 1957</u> , that I last saw the deceased alive on <u>April 16, 1957</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. J. Brennan</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Bethesda, Md. 4-16-57</u>	
PHYSICIAN'S NAME (Type) <u>A. J. BRENNAN</u>		<u>4630 Montgomery Ave, Bethesda, Md.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Transportation 4/16/57</u>	22b. DATE THEREOF <u>4/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trenton, New Jersey</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 4-22-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bea M. Shonifson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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APR 21 1957
BUREAU V. S.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4311

CERTIFICATE OF DEATH

Reg. Dist. No.

043034

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>13 days</u>				d. STREET ADDRESS <u>12524 Epping Court</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jda</u> Middle <u>S.</u> Last <u>Searle</u>				4. DATE OF DEATH Month <u>4</u> Day <u>-10-</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 12, 1874</u>	
9. AGE (In years lost birthday) <u>82</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Stevens</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Elizabeth Jones</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO <u>YES</u>				17. INFORMANT Address <u>Mrs. Paul J. Stubbs, 12,524 Epping Court Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anterograde renal disease</u> DUE TO <u>1 year</u> (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1 Jan., 1957</u> to <u>9 Apr., 1957</u> , that I last saw the deceased alive on <u>9 Apr., 1957</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Seruch T. Kimble</u> M.D. <u>929 Pennington Drive Silver Spring, Md 20901</u>				DATE SIGNED <u>10 Apr 1957</u>			
PHYSICIAN'S NAME (Type) <u>SERUCH T. KIMBLE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRIAL & BURIAL</u>		<u>4/13/57</u>		<u>OSKALOOSA CEMETERY</u>		<u>OSKALOOSA, KANSAS</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>4/13/57</u>		24b. REGISTRAR'S SIGNATURE <u>Francis Toller</u>	

RECEIVED
APR 17 1917
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST HYATTSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDEN SANITARIUM				d. STREET ADDRESS 3507 NICHOLSON			
3. NAME OF DECEASED (Type or print) First Middle Last (LOUIS) LUIGI SERRA				4. DATE OF DEATH Month Day Year APRIL 14 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 18, 1888		9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHEF		10b. KIND OF BUSINESS OR INDUSTRY HOTEL Retired		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FIDELA SERRA				14. MOTHER'S MAIDEN NAME MARY MORELLO			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes 1940-1945		16. SOCIAL SECURITY NO 1-24-66		17. INFORMANT Address ELIO V SERRA 3507 NICHOLSON			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure + Coma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Jaundice + Cirrhosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 month 7.5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease - Chronic Renal Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from 8/1 , 19 56 , to 6/14 , 19 57 , that I last saw the deceased alive on 4/7 , 19 57 , and that death occurred at 3:46 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Frank M Trozzo Jr. M.D. 1840 Michigan Ave N.E. DC 4/14/57							
ACTUAL SIGNATURE Frank M Trozzo Jr.							
PHYSICIAN'S NAME (Type) FRANK M. TROZZO JR M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-17-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Neal Funeral Home				ADDRESS 4812 2nd Ave N.E.		24. REGISTRAR'S SIGNATURE Frances Tetter	

BUREAU V. S.

1902

RECEIVED

4189

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patoma Park</u>		c. LENGTH OF STAY IN 1b <u>3-3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leesington Hospital & Sanatorium</u>		d. STREET ADDRESS <u>7913 Piney Branch Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Kemper</u> Middle <u>James</u> Last <u>Shifflet</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1894</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reporter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Shifflet</u>		14. MOTHER'S MAIDEN NAME <u>Martha Shifflett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>W.D.I.</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Blanche Shifflett</u>		Address <u>7913 Piney Branch Rd., SS., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with metastases</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street office-bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 21, 1957</u> to <u>Apr. 14, 1957</u> , that I last saw the deceased alive on <u>April 14, 1957</u> , and that death occurred at <u>6:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Willard Camaker, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>1801 Eye St. N.W., Wash. D.C.</u>	
DATE SIGNED <u>4-14-57</u>			
PHYSICIAN'S NAME (Type) <u>C. WILLARD CAMAKER, JR.</u>		<u>Wash. D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Samblan's son</u>		ADDRESS <u>Washington</u>	
24a. REC'D BY REGISTRAR <u>William Drell</u>		DATE <u>4/17/57</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04306

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4190 Item 14 Primary 14-12-57 et

Reg. Dist. No. 22-3

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSTVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM & HOSPITAL</u>				d. STREET ADDRESS <u>2412 LEWISDALE DRIVE</u>			
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>ESTHER</u> Last <u>SIRMAI</u>				4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-19-92</u>	
9. AGE (in years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Hungary</u>	
12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>							
13. FATHER'S NAME <u>Jacob Marmelstein</u>				14. MOTHER'S MAIDEN NAME <u>Marion (Last name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hosp. Record - MR MORRIS SIRMAI</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEIT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4-3-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/4-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Georgetown Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Wash. DC</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>4/6/57</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

L

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar by mail, telegram, or removal.

RECEIVED

APR 3 1957

BUREAU V

4313

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban			d. STREET ADDRESS 5505 Sonoma Road		
3 NAME OF DECEASED (Type or print) First Edward Middle Ehrlich Last Smith			4. DATE OF DEATH Month April Day 11 , Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH January 27, 1885		9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Alexander Coke Smith			14 MOTHER'S MAIDEN NAME Katherine Kinand		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17 INFORMANT Mrs. Katherine Warren- 5505 Sonoma Road Bethesda, Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure, Acute 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic calcific mitral stenosis DUE TO (c) ? INTERVAL BETWEEN ONSET AND DEATH few hrs ? years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Confluent bronchopneumonia, both lungs.					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)			20g. (County)		20h. (State)
21. I certify that I attended the deceased from Apr. 8, 19 57 to Apr. 11, 19 57 that I last saw the deceased alive on Apr. 11, 19 57 , and that death occurred at 5:30 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE George A. Gray, Jr.			ADDRESS (Street, city or town, state) 104 Chevy Chase Dr., Chevy Chase 15, Md.		
PHYSICIAN'S NAME (Type) George A. Gray, Jr. M.D.			DATE SIGNED 4/12/57		
22a. BURIAL CREMATION, Cremation		22b DATE THEREOF 4/12/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
22d LOCATION (City, town, or county) Suitland, Md.		22e (State) Md.		22f. (City or town)	
23 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.			24a. REC'D BY REGISTRAR DATE 4-18-56		
24b REG STRAR'S SIGNATURE Bennie M. Thompson			24c. (City or town)		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 22 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4314

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3704 Taylor Street				d. STREET ADDRESS 3704 Taylor Street			
3. NAME OF DECEASED (Type or print) HARRY ORLANDO SMITH				4. DATE OF DEATH Month April Day 12 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mch 19, 1882	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 0 Days 23		11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. USMC				10b. KIND OF BUSINESS OR INDUSTRY USMC		11. BIRTHPLACE (State or foreign country) Vermont	
13. FATHER'S NAME Frank Smith				14. MOTHER'S MAIDEN NAME Slayton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W. W. I		17. INFORMANT Lucy W. Smith-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit				22b. DATE THEREOF 4/15/1957		22c. NAME OF CEMETERY OR CREMATORY River Bank	
				22d. LOCATION (City, town, or county) Lamoille County		(State) Vermont	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.				24a. REC'D BY REGISTRAR APR 17 1957		24b. REGISTRAR'S SIGNATURE <i>Bessie Thompson</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 17 1957

RECEIVED

CERTIFICATE OF DEATH

04309

Reg. Dist. No.

216

4315

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Smothers Last Smothers		4. DATE OF DEATH Month April Day 13 Year 1957	
5. SEX MALE	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME MOSES Unknown		14. MOTHER'S MAIDEN NAME Victoria Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Corva Davis - 4125 Pyles Rd Kensington, Md	
17. INFORMANT Corva Davis - 4125 Pyles Rd Kensington, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 525x DUE TO Right Heart Failure		(b) Pulmonary Fibrosis, Arteriosclerosis, Plavacyclid Therapy, etc.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Pyelonephritis & Nephrosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 Sept. 1957 , to 13 April 1957 , that I last saw the deceased alive on 12 April 1957 , and that death occurred at 11:34 AM , from the causes and on the date stated above.			
22a. BLR AL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/57	
22c. NAME OF CEMETERY OR CREMATORY ANH MEMORIAL		22d. LOCATION (City, town, or county) (State) SANDY SPRING, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden & Son		24. REC'D BY REGISTRAR APR 18 1957	
25. ADDRESS 1134 George Ave SE		26. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 19 1967

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 215

4316

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>31 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>				d. STREET ADDRESS <u>613 N. Howard Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Michael</u> Last <u>SNOW</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>25 April 1957</u>	
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Donald Joseph Snow</u>				14. MOTHER'S MAIDEN NAME <u>Patricia Carol Garrison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT (Father) <u>Donald J. Snow (Same As #1)</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Respiratory failure</u> DUE TO (c) <u>Marked prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>3 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>25 April</u> 19 <u>57</u> , to <u>28 April</u> 19 <u>57</u> , that I last saw the deceased alive on <u>28 April</u> 19 <u>57</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>4-29-57</u>							
ACTUAL SIGNATURE <u>John H. Mazur</u> M.D.				U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) <u>John H. Mazur, L.D., M.C., U.S.</u>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-1-57</u>		<u>Arlington Nat'l Cemetery</u>		<u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Ramsey</u> ADDRESS <u>1001 Wisconsin Ave., Bethesda, Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Mary B. Russell</u>	
DATE <u>4-29-57</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 1 1957

BUREAU V. N.

4317

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admittance) a STATE Maryland b COUNTY Montgomery			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c LENGTH OF STAY IN 1b 69 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d STREET ADDRESS 2212 Henderson Avenue		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Gregory Middle George Last Sorrows				4 DATE OF DEATH Month April Day 1 Year 57			
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH January 23, 1955		9 AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Howard Sorrows				4 MOTHER'S MAIDEN NAME Margaret J. Summerville			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO None		17 INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sympathetic atherosclerosis DUE TO 2021 (b) To atherosclerotic heart disease DUE TO Increased intracranial pressure (c) 6 months							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 month							
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f (City or town) (County) (State)			
27. I certify that I attended the deceased from January 22, 1957 to April 1, 1957 , that I last saw the deceased alive on April 1, 1957 , and that death occurred at 9:20 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) The Clinical Center				DATE SIGNED April 1, 1957			
ACTUAL SIGNATURE Gurston Goldin M.D.							
PHYSICIAN'S NAME (Type) Gurston Goldin, M.D.							
22a BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/3/57		22c NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d LOCATION (City, town or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MD.				24a REC'D BY REGISTRAR 4-6-57		24b REGISTRAR'S SIGNATURE Bernard M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 3 1957

BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04312216**

4318

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp				d. STREET ADDRESS 607 Delafield Place			
3. NAME OF DECEASED (Type or print) First Edward Middle H. Last Spellman				4. DATE OF DEATH 4/26/57 Month Day Year			
5. SEX male		6. COLOR OR RACE col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 1/29/26		9. AGE (In years, <small>days</small> birthday) 31 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. J.			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Frank Y Spellman			
14. MOTHER'S MAIDEN NAME Lillian Howles				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Police Record			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution 7146 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Placing metal ladder against building & contacted high vol. wires							
20c. TIME OF INJURY Month, Day, Year 9:50 a.m. 4/26/57		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Woodmont Country Club Rockville Montg. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4/26/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4/27/57		22c. NAME OF CEMETERY OR CREMATORY Charles L. Whigham Fun. Home			
22d. LOCATION (City, town, or county) (State) Newark, N. J.		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert L. Snowden Rockville, Md.					
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE APR 30 1957					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-10. Page 1 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

RECEIVED

APR 30 1957

BUREAU V. S.

04313

4191

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Pennsylvania</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gettysburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hospital</i>		d. STREET ADDRESS <i>Route 1 - Box 77</i>	
3. NAME OF DECEASED (Type or print) First <i>LAURA</i> Middle <i>MAE</i> Last <i>STEBBINS</i>		4. DATE OF DEATH Month <i>4</i> Day <i>16</i> Year <i>1957</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-6-89</i>
9. AGE (In years last birthday) <i>68</i> yrs		IF UNDER 1 YEAR: Months <i>6</i> Days <i>16</i> Hours <i>19</i> Min. <i>57</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Illinois</i>	
11. BIRTHPLACE (State or foreign country) <i>Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edwin Lewis</i>		14. MOTHER'S MAIDEN NAME <i>Florence Colvin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Old Records - and patient</i>	
17. INFORMANT Address <i>Old Records - and patient</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> DUE TO <i>Primary Carcinoma gall bladder</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>11 years</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Subacute retend and conditions</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/24</i> , 19 <i>57</i> , to <i>4/16</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>4/16</i> , 19 <i>57</i> , and that death occurred at <i>10:25</i> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Chas H. Wolohon</i> M.D.		ADDRESS (Street, city or town, state) <i>7401 Blue Ridge NW Washington, D.C.</i>	
PHYSICIAN'S NAME (Type) <i>Chas H. Wolohon</i>		DATE SIGNED <i>Washington, D.C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>April 19, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Prince Georges Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walters</i> ADDRESS <i>254 Carroll St NW</i>		24a. REC'D BY REGISTRAR <i>19 1957</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur Walters</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 22 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4192

CERTIFICATE OF DEATH

Reg. Dist. N 1313

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
c. LENGTH OF STAY IN 1b <u>45 MIN.</u>				d. STREET ADDRESS <u>12716 Feldon ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>Jay</u> Last <u>STEIN</u>				4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-12-57</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR: Months <u>9</u>		IF UNDER 24 HRS: Days <u>9</u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11 BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>			
12 CITIZEN OF WHAT COUNTRY							
13. FATHER'S NAME <u>PAUL STEIN</u>				14. MOTHER'S MAIDEN NAME <u>ADELE WHITE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Paul STEIN</u>				Address <u>12716 Feldon ST., Wheaton,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Obstruction</u> DUE TO <u>Laryngo-tracheo-bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Pneumonia</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>MD</u> <u>10 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3-12-57</u> to <u>4-21-57</u> , that I last saw the deceased alive on <u>4-21-57</u> , and that death occurred at <u>9:10</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David L. Weinstein</u>				M.D. <u>3222 Douglass St. N.W.</u>			
PHYSICIAN'S NAME (Type) <u>David L. Weinstein</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parlson</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Hamanek & Sons</u>				ADDRESS <u>3501-14th St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>4/24/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>William K. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A

APR 26 1957

RECEIVED

4319

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived If inst. in hon. Residence before adm. ssion) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 708 Brent Road	
3 NAME OF DECEASED (Type or print) First Anna Middle H. Last Stimek		4. DATE OF DEATH Month April Day 10 Year 1957	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-16-82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at Home	9 AGE (In years last birthday) 74 yrs.
11 BIRTHPLACE (State or foreign country) Lithuania		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME George Srigatis		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16 SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	
17 INFORMANT Joseph Stimek — as above		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 mos 15 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3 April , 19 57 , to 1 April , 19 57 , that I last saw the deceased alive on 11 April , 19 57 , and that death occurred at 4:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. S. Humphrey		DATE SIGNED 6:15 W. Humphrey Rockville, Md. April 10, 1957	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	4/15/57	Holy Redeemer Com	4430 Belair Rd.
23. FUNERAL DIRECTOR'S SIGNATURE X John J. Lowan		24a. REC'D BY REGISTRAR APR 12 1957	24b. REGISTRAR'S SIGNATURE Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 17 1917

RECEIVED

4320

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland c. LENGTH OF STAY IN 1b 209 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE D. C. b. COUNTY MD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 16, d. STREET ADDRESS 6207 Cromwell Drive, Woodacres e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Raymond Middle Paul Last Sullivan		4. DATE OF DEATH Month April Day 2 Year 1957	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 3, 1917
9 AGE (in years last birthday) 39		F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Analyst		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert Sullivan		14. MOTHER'S MAIDEN NAME Anne Raynor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes WW II		16. SOCIAL SECURITY NO Not Available	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Embryonal cell carcinoma, metastatic DUE TO (c) to lungs, kidneys, lymph nodes		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 15 mos.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 5, 1956 , to April 2, 1957 , that I last saw the deceased alive on April 2, 1957 , and that death occurred at 2:15 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE William J. Pieper		DATE SIGNED 4/2/57	
PHYSICIAN'S NAME (Type) William J. Pieper, M. D.			
22a. BURIAL CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 4/5/57	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.	22d. LOCATION (City, town, or county) (State) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR 4-3-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

BUREAU V. S.

APR 5 1951

RECEIVED

4193

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b Washington San and Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				d. STREET ADDRESS 608 Forest Glen Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Myrtle Louise Swain				4. DATE OF DEATH Month April Day 27 Year 1957				5. SEX Female				6. COLOR OR RACE white				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Jan. 24, 1880				9. AGE (In years last birthday) 77 yrs.				10. IF UNDER 1 YEAR Months 3 Days 3				11. IF UNDER 24 HRS. Hours 3 Min. 19			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY at home				11. BIRTHPLACE (State or foreign country) Columbus, Neb.				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME ? Parker				14. MOTHER'S MAIDEN NAME Mary Louise ?															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no				17. INFORMANT Mrs Katherine Kearns				Address 608 Forest Glen Rd				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Obstruction of lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Obstruction of lung DUE TO Obstruction of lung (c) Obstruction of lung				INTERVAL BETWEEN ONSET AND DEATH 2 wks															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) Prince Geo. Co., Md				(County) Prince Geo. Co.				(State) Md															
21. I certify that I attended the deceased from Jan 23, 1957 to Apr 27, 1957 , that I last saw the deceased alive on 4-27 , 19 57 , and that death occurred at 10:01 PM , from the causes and on the date stated above.																																			
ACTUAL SIGNATURE Katherine Kearns				M.D. 4-27-57				ADDRESS (Street, city or town, state) 608 Forest Glen Rd				DATE SIGNED 4-27-57																							
PHYSICIAN'S NAME (Type) W. C. ...																																			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation				22b. DATE THEREOF 4/29/57				22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln				22d. LOCATION (City, town, or county) Prince Geo. Co., Md				(State) Md																			
23. FUNERAL DIRECTOR'S SIGNATURE W. C. ...				ADDRESS ...				24a. REC'D BY REGISTRAR APR 30 1957				24b. REGISTRAR'S SIGNATURE ...																							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04318

Reg. Dist. No.

214

4321

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>8 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2410 Danow St.</u>				d. STREET ADDRESS <u>2410 Danow St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Abner</u> Last <u>Teate</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 25 1894</u>	9. AGE (In years last birthday) <u>62 yrs.</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Fla</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANCIS ABNER TEATE</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE E. (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>578-05-6829</u>		17. INFORMANT <u>Frank Teate (son)</u> Address <u>Kensington Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>4/8/57</u>	
				24b. REG STRAR'S SIGNATURE <u>Francis Potter</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

RECEIVED

APR 10 1957

BUREAU A. S.

4191

CERTIFICATE OF DEATH

Reg. Dist. No. 273

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Res. dence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San Hosp</u>				d. STREET ADDRESS <u>18604 Mayfair Place</u>			
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Albert</u> Last <u>Theodore</u>				4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-14-1898</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Marine Corp.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>La</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Emil Theodore</u>				14. MOTHER'S MAIDEN NAME <u>Clarisse Ross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I and WW II</u>				16. SOCIAL SECURITY NO. <u>217-28-8440</u>			
17. INFORMANT <u>Hosp Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive cerebral hemorrhage (nt. side)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 hrs</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>May 7, 1953</u> to <u>April 6, 1957</u> that I last saw the deceased alive on <u>April 6, 1957</u> , and that death occurred at <u>1036 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kenneth F. Laughlin</u>				ADDRESS (Street, city or town, state) <u>934 Ellsworth Dr. Silver Spring, Md.</u>		DATE SIGNED <u>4-6-57</u>	
PHYSICIAN'S NAME (Type) <u>KENNETH F. LAUGHLIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u>				ADDRESS <u>8434 90th St. S.S. Md</u>		24a. REC'D BY REGISTRAR DATE <u>4/9/57</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Edmund Dolt</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 12 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04320

4322

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>2 mos. 17 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>712 "F" St., S.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Victoria</u> Last <u>THOMPSON</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negroid</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7 Nov. 1953</u>
9. AGE (In years lost birthday) yrs. <u>3</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Francis Xavier Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Gloria Sparrow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO <u>None</u>	17. INFORMANT <u>(Father) Francis X. Thompson, (Same As #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>591X</u> DUE TO <u>subacute glomerulonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Lipoid nephrosis</u> DUE TO <u>6 mo</u> (c) <u>acute pancreatitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>acute pancreatitis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. r. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>25 Jan. 1957</u> , 19 <u>57</u> , to <u>12 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12 April</u> , 19 <u>57</u> , and that death occurred at <u>8:20 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>4-13-57</u>			
ACTUAL SIGNATURE <u>Howard A. Pearson</u> M.D.		U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) <u>HOWARD A. PEARSON, LT, MC, USN</u>		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-16-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.H. Bacon</u>		24a. REC'D BY REGISTRAR <u>4-12-57</u>	
ADDRESS <u>Wash. D.C.</u> <u>1722 7th St., N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Russell</u>	

W.H. Bacon 1722-7th St NW

BUREAU V. S.

APR 27

RECEIVED

4195

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL (If not in hospital, give street address) Washington Sanitarium & Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 1515 Grace Church Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Cora Lafolia Van Gasken				4. DATE OF DEATH Month Day Year April 2 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-10-72	
9. AGE (In years last birthday) 84 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? America				13. FATHER'S NAME James Seitzinger			
14. MOTHER'S MAIDEN NAME Hannah Ebert				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 100-100-1000				17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden acute heart disease 587 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Bronchial pneumonia (c) Persistent drainage from ruptured heart PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Fracture of left hip Parathyroid gland						INTERVAL BETWEEN ONSET AND DEATH 18 hrs. 48 hrs. 2 1/2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Yes				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Hip collapsed and patient fell			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 3-15-57				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Silver Spring, Md.				20g. (County) Montgomery			
20h. (State) Md.				21. I certify that I attended the deceased from June 1948 to April 2, 1957 , that I last saw the deceased alive on April 1, 1957 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
21a. ACTUAL SIGNATURE John S. Rogers M.D.				21b. ADDRESS (Street, city or town, state) 1919 Lemmon Rd. Silver Spring, Md.			
21c. DATE SIGNED 4-2-57				21d. PHYSICIAN'S NAME (Type) JOHN S. ROGERS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/5/57		22c. NAME OF CEMETERY OR CREMATORY SHAMOKIN CEMETERY		22d. LOCATION (City, town, or county) (State) SHAMOKIN, PENNSYLVANIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warren E. Murphy				23a. ADDRESS 8434 Go Ave		23b. REG'D BY REGISTRAR APR 5 - 1957	
23c. REGISTRAR'S SIGNATURE John S. Rogers				23d. REGISTRAR'S NAME John S. Rogers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 8 1957

BUREAU V. E.

*D. V. Gussel
not filed and
closed. H. P.*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 214										
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN 1b 16 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 14720 Colesville Rd.					d. STREET ADDRESS Colesville Rd			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Anne Middle Wilhelmina Last Veith					4. DATE OF DEATH Month April Day 5 Year 1957					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/24/1898		9. AGE (In years last birthday) 58 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Germany			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Emil Robemacher					14. MOTHER'S MAIDEN NAME Anna Scoffel					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes		17. INFORMANT Address Adolph Veith(husband) Same as Item 2						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Carbon monoxide poisoning - suicide Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Found dead in car in closed garage (c) garage										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Found dead on front seat of car in closed garage										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Found dead on front seat of car in closed garage								
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Montgomery County, Maryland		20g. (State) Maryland		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Frank J. Broschart					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Frank J. Broschart					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4/6/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/9/57		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY			22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey					ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 4/8/57		24b. REGISTRAR'S SIGNATURE Graves Teller	

04322

4323

Reg. Dist. No. 214

U.S. AIR FORCE

10 1957

RECEIVED

4324

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedarcroft San Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Idaho</u> b. COUNTY <u>N.W.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harold B. Vollrath</u>		4. DATE OF DEATH <u>April 14th 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 26-1896</u>
9. AGE (In years last birthday) <u>61</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>1</u> Days <u>14</u> Hours <u>14</u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemical engineer (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Alfred J. Vollrath</u>		14. MOTHER'S MAIDEN NAME <u>Rosalie Benson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Admission Card record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Cardio Vascular Sclerotic disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) <u>also was psychotic-hypomanic type</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Coronary heart disease. Had previous coronary infarction</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 10, 1957</u> to <u>April 14, 1957</u> , that I last saw the deceased alive on <u>April 14th 1957</u> , and that death occurred at <u>6:02 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alvin J. Kistler</u> M.D.		DATE SIGNED <u>4-14-57</u>	
PHYSICIAN'S NAME (Type) <u>Alvin J. Kistler, M.D.</u>		ADDRESS (Street, city or town, state) <u>Cedarcroft San Hosp Silver Spring Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Samuels</u>		24a. REC'D BY REGISTRAR <u>4-25-57</u>	
24b. REGISTRAR'S SIGNATURE <u>James C. Miller</u>		24c. ADDRESS <u>1753 Pennsylvania Ave NW, Washington, DC</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4325

CERTIFICATE OF DEATH

04324

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE District of Columbia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 35 days 13 hrs.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Max Middle L. Last Waeber			4. DATE OF DEATH Month 4- Day 28 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1883		9. AGE (In years lost birthday) yrs 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect		10b. KIND OF BUSINESS OR INDUSTRY Retired-Gov't		11. BIRTHPLACE (State or foreign country) Switzerland	
13. FATHER'S NAME ? Waeber			14. MOTHER'S MAIDEN NAME ? Lang		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Wife Address Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Colon & Metastases to liver & lungs. DUE TO (c) Lungs.					INTERVAL BETWEEN ONSET AND DEATH 4/11 8 Mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardio Vascular disease - and - Parkinson Disease -					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Nov 19 54 , to date 19 57 , that I last saw the deceased alive on April 26 19 54 , and that death occurred at 4:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7936 Old Georgetown Rd. Bethesda, Md. DATE SIGNED 29 April 57					
ACTUAL SIGNATURE John G. Ball M.D.					
PHYSICIAN'S NAME (Type) John G. Ball, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Rock Creek	
22d. LOCATION (City, town, or county) Washington		(State) D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md			24a. REC'D BY REGISTRAR DATE 5-2-57		24b. REGISTRAR'S SIGNATURE Bessie M. Shornfean

BUREAU V. T.

MAY 3 1957

RECEIVED

4326

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden San</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katharine</u> Middle <u>Walters</u> Last <u>Walters</u>		4. DATE OF DEATH Month <u>4</u> - Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-'64</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Gov't Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William T. Duvall</u>		14. MOTHER'S MAIDEN NAME <u>Jane Sedgwick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. K. Burr Ellinger</u> Address <u>Wob-3197</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Severe coronary sclerosis</u> (c) <u>Advanced arteriosclerosis & senility</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile dementia</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>1946</u> to <u>April 8, 1957</u> , that I last saw the deceased alive on <u>3-28-1957</u> , and that death occurred at <u>5:49 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) <u>3921 Ingomar St. N.W.</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		DATE SIGNED <u>4-8-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>4/10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Jewinsville Cent.</u>		22d. LOCATION (City, town, or county) (State) <u>Jewinsville, Fairfax Cty. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph A. Erickson</u>		ADDRESS <u>3034 F St. N.W., D.C.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>	

BUREAU V. S.

APR 12 1957

RECEIVED

CERTIFICATE OF DEATH

04326

Reg. Dist. No.

4327

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>China</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taipei-Formosa</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>2 Lane 245 Shu-Lane</u> <u>maining road-T</u>	
3. NAME OF DECEASED (Type or print) First <u>Kuang</u> Middle <u>Yao</u> Last <u>WANG</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Chinese</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 Feb. 1910</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier (Maj. Gen.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Free Chinese Army</u>	
11. BIRTHPLACE (State or foreign country) <u>China</u>		12. CITIZEN OF WHAT COUNTRY? <u>China</u>	
13. FATHER'S NAME <u>In Chu WANG</u>		14. MOTHER'S MAIDEN NAME <u>Chen Chu CHING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Official Navy Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage, Pulmonary</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma, Bronchogenic</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>9 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9 Feb.</u> 19 <u>57</u> to <u>25 April</u> 19 <u>57</u> , that I last saw the deceased alive on <u>25 April</u> 19 <u>57</u> , and that death occurred at <u>8:50</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>R. J. Mc Carthy</u> M D <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>4-26-57</u>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>R. J. MC CARTHY, CDR, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Cremation</u>	<u>4-30-57</u>	<u>Cedar Hill Crematory</u>	<u>Prince George, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Mc Carthy</u>		24a. REC'D BY REGISTRAR <u>DATE 4-26-57</u>	
ADDRESS <u>Wiscousin Ave., Bethesda, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Carthy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. M.

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4328
CERTIFICATE OF DEATH

Reg. Dist. No.

04327
216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Bethesda</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C. Wash.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmore Hospital Sanitarium</u>		d. STREET ADDRESS <u>5211-39 St. N.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sylvestre</u> First <u>A</u> Middle <u>Hard</u> Last		4. DATE OF DEATH <u>April</u> Month <u>19</u> Day <u>17</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 12, 1873</u> 83 yrs.
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Construction Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>John Ward</u>		14. MOTHER'S MAIDEN NAME <u>Jane Mackey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Dr. Crowley</u>		Address <u>5211 39th NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY INFECTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PULMONARY HEART DISEASE</u> DUE TO <u>EMPHYSEMA CHRONIC</u> (c) <u>CONGESTIVE HEART FAILURE</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>10+ YRS</u> <u>20+ YRS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/7/1957</u> to <u>4/9/1957</u> , that I last saw the deceased alive on <u>4/7/1957</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles J. Savarese</u> M.D.		ADDRESS (Street, city or town, state) <u>4812 Battery Lane</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE, Jr Bethesda, Md</u>		DATE SIGNED <u>4/9/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-12-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Westminster</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u>		ADDRESS <u>4812 2nd Ave NW</u>	
24a. REC'D BY REGISTRAR <u>APR 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Beatrix Thompson</u>	

RECEIVED

APR 11 1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

04328

218

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ASBURY METHODIST HOME</u>		d. STREET ADDRESS <u>26 Sherwood Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET ELIZABETH WAREHEIM</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 29 1873</u> <u>BH</u> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md. WESTMINSTER, CARROLL, Co.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>MILTON DEVLBISS</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA WARD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-32-1218A</u>	
17. INFORMANT <u>Mr. Paul E. Wareheim-706 Brookwood Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>444x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE & CONGESTIVE FAILURE</u> DUE TO (c) <u>BILATERAL PNEUMONIA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 18</u> 1957, to <u>APRIL 8</u> 1957, that I last saw the deceased alive on <u>APRIL 6</u> 1957, and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Sarah E. Glover</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 4208 Anthony ST. Kensington Md 4/8/57</u>	
PHYSICIAN'S NAME (Type) <u>Sarah E Glover</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Am. J. Dickerson & Sons - Balto</u>		24a. REC'D BY REGISTRAR <u>11-1357</u> DATE <u>4/12/57</u> 24b. REGISTRAR'S SIGNATURE <u>Alvin J. Glover</u>	

BUREAU V. S.

APR 16 1957

RECEIVED

4196

CERTIFICATE OF DEATH

Reg. Dist. No. 2-2

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen. Hosp</u>				d. STREET ADDRESS <u>581 University Blvd. E</u>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>none</u> Last <u>Weidlich</u>				4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-19-79</u>	
9. AGE (In years last birthday) <u>77</u> yrs		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>19</u> Min. <u>57</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Julius Schoenfeldt</u>				14. MOTHER'S MAIDEN NAME <u>Pauline JUNGHANS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Charles A. Hest</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral & Vascular Encephalopathy</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Complicated Heart Failure</u> DUE TO (c) <u>Septic</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 Days</u> <u>4 Mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Atherosclerosis 15 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Apr 8, 1956</u> , to <u>Apr 5, 1957</u> , that I last saw the deceased alive on <u>Apr 5, 1957</u> , and that death occurred at <u>10:03 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kenneth F. Laughlin</u> M.D.				ADDRESS (Street, city or town, state) <u>9346 Elsworth Dr., Silver Spring, Md.</u>			
DATE SIGNED <u>4-5-57</u>							
PHYSICIAN'S NAME (Type) <u>KENNETH F. LAUGHLIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Soldiers Home Nat'l. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>Silver Spring 8434 8a Ave Md.</u>				24a. REC'D BY REGISTRAR DATE <u>4/8/57</u>		24b. REGISTRAR'S SIGNATURE <u>William D. ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 9 1957

RECEIVED

4197

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 18 Hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4700 d. STREET ADDRESS 6311 Kansas Ave. N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print) Mina First (NMN) Middle Weikers Last			4. DATE OF DEATH Month April Day 20 Year 1957				
5 SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8 DATE OF BIRTH I-24-77		9 AGE (In years last birthday) yrs. 80		F UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Germany		11. BIRTHPLACE (State or foreign country) America			
13. FATHER'S NAME Aaron Sichel			14. MOTHER'S MAIDEN NAME Yettie Sichel				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia left lower lobe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, 900.0 (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis. Intercostal fracture left rib. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Misjudged bottom step at home & fell. 20c. TIME OF INJURY Month, Day, Year Hour a. m. 5 p. m. April 19 1957 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Washington D. C.					INTERVAL BETWEEN ONSET AND DEATH 2 days		
21. I certify that I attended the deceased from April 19, 1957 , to April 20, 1957 , that I last saw the deceased alive on April 20, 1957 , and that death occurred at 6:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7210 Columbia Rd., Silver Spring, Md. DATE SIGNED 4/20/57 ACTUAL SIGNATURE Sydney L. Larenthal NAME (Type) Sydney L. Larenthal M.D. 7210 Columbia Rd., Silver Spring, Md.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 20 1957		22c. NAME OF CEMETERY OR CREMATORY ACHDUTH CHEVRA			
22d. LOCATION (City, town, or county) (State) HYATTSVILLE MD		23. FUNERAL DIRECTOR'S SIGNATURE B. Langansky ADDRESS 3501-14 St. N.W.		24. REC'D BY REGISTRAR APR 23 1957 24b. REGISTRAR'S SIGNATURE J. H. D. D.			

BUREAU V. S.

APR 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04331

Reg. Dist. No. 216

4330

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>1 Year</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4915 Hampden Lane</u>				d. STREET ADDRESS <u>4915 Hampden Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harold William Wepfer</u>				4. DATE OF DEATH Month Day Year <u>April 29 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/9/1901</u>		9. AGE (In years last birthday) <u>56 yrs.</u>	IF UNDER 1 YEAR Months Days <u>3 20</u>	IF UNDER 24 HRS. Hours Min. <u>20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Dealer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Wepfer</u>				14. MOTHER'S MAIDEN NAME <u>Mabel Gray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <u>Zahorka Wepfer</u> Address <u>Norma Gray, Item #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Found dead in auto</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found dead in auto in enclosed garage (left Note)</u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/29/57</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur.-Transit</u>		22b. DATE THEREOF <u>4/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Marshfield</u>		22d. LOCATION (City, town, or county) (State) <u>Marshfield, Wis.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 5-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

RECEIVED

MAY 3 1957

BUREAU V. E.

4331

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Paral.)</u>				c LENGTH OF STAY IN 1b <u>158 days</u>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>			
d STREET ADDRESS <u>154 Circle Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Shirley</u> Last <u>WHITE</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>19 57</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>31 May 1923</u>	
9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Leroy Milsap</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Hayes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Husband, Henry Q. White, (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of kidney</u> <u>180 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with multiple metastases</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>18 mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10 Nov.</u> , 19 <u>56</u> , to <u>16 April</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>16 April</u> , 19 <u>57</u> , and that death occurred at <u>11:00 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Byron D. Casteel</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>				<u>4-18-57</u>			
PHYSICIAN'S NAME (Type) <u>Byron D. Casteel, CAPT, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4-19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Penney</u>				ADDRESS <u>7557 Wisconsin Ave., Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>4-17-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary E. Penney</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 22 1967

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04333

4198

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in-hospital, give street address) <u>Washington Sun. Termin + Hospital</u>				d. STREET ADDRESS <u>4336 Leland St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED First Middle Last <u>Elizabeth Kutmire</u>				4. DATE OF DEATH Month Day Year <u>4 7 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-13-88</u>	
9. AGE (In years lost birthday) yrs <u>69</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life) even if retired <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Joseph Morris Smith</u>				14. MOTHER'S MAIDEN NAME <u>Eltha Connors</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>MRS. Edith S. Ross, 4336 Leland St. S. D. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(a) Rheumatic Heart Disease</u> <u>411X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>(b) Aortic Insufficiency, E</u> DUE TO (c) <u>(c) Congestive Failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. pt. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Nash, D.C.</u>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 6, 1956</u> , to <u>April 7, 1957</u> , that I last saw the deceased alive on <u>April 6, 1957</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. H. Wolohin</u>				ADDRESS (Street, city or town, state) <u>7401 Blau Road NW, Wash, D.C.</u>			
DATE SIGNED <u>4/9/57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Columbia Nat. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Columbia, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Wolohin</u>				ADDRESS <u>254 E. Capitol St. NW</u>		24a. REC'D BY REGISTRAR DATE <u>4/9/57</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Arthur Wolohin</u>							

BUREAU V. S.

1957

RECEIVED

4332

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 1317 Woodside Parkway	
3 NAME OF DECEASED (Type or print) Herbert A. Wilkinson		4. DATE OF DEATH Month 4 Day 10 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/18/07
9. AGE (In years last birthday) yrs. 49		10. IF UNDER 1 YEAR: Months 4 Days 10 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Economist		10b. KIND OF BUSINESS OR INDUSTRY US Government	
11. BIRTHPLACE (State or foreign country) South Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Herbert S. Wilkinson		14. MOTHER'S MAIDEN NAME Margaret DeCon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Katherine (wife)		Address 1317 Woodside Parkway Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 6 weeks 1 year	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Infarction (old)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 21, 1947 , to April 10, 1957 , that I last saw the deceased alive on April 9, 1957 , and that death occurred at 1:00 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) 8248 Georgia Ave. Silver Spring, Maryland DATE SIGNED 4/10/57			
ACTUAL SIGNATURE Herrill M. Cross M.D.			
PHYSICIAN'S NAME (Type) HERRILL M. CROSS		Silver Spring, Maryland	
22a. BURIAL, CREMATION, (REMOVAL) (Specify) Cremation	22b. DATE THEREOF April 10, 1957	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory	22d. LOCATION (City, town, or county) (State) Prince Georges Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. E. Gimpsey		ADDRESS 5424 Georgia Ave Silver Spring, Md.	
24a. REC'D BY REGISTRAR DATE 4-11-57		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 12 1957

RECEIVED

4190

CERTIFICATE OF DEATH

Reg. Dist. No. 227

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Rt. Frederick</u>	
c. LENGTH OF STAY IN 1b <u>23 days</u>		d. STREET ADDRESS <u>Town & P.O. (None) Ijamsville, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Effie Elizabeth</u> Middle <u>Wills</u> Last <u>Wills</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 25, 1902</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George W. Iddings</u>	
14. MOTHER'S MAIDEN NAME <u>Effie Virginia Young</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis & pleural effusion - massive - bilateral</u> <u>175X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Carcinomatosis - Abdomen & Chest</u> DUE TO (c) <u>Carcinoma of both Ovaries</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos ±</u> <u>6 mos ±</u> <u>9 mos ±</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>None recently</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 8, 1957</u> to <u>April 11, 1957</u> , that I last saw the deceased alive on <u>April 11, 1957</u> , and that death occurred on <u>8:53 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Read N. Calvert, M.D.</u>		ADDRESS (Street, city or town, state) <u>7894 Georgia Ave., M.D.</u>	
PHYSICIAN'S NAME (Type) <u>READ N. CALVERT, M.D.</u>		DATE SIGNED <u>Silver Spring, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/15/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son-Frederick, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>4/15/57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 17 1957

BUREAU V. S.

4333

CERTIFICATE OF DEATH

Reg. Dist. No.

043336/6

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 883 Boulevard East	
3. NAME OF DECEASED (Type or print) First Harriet Middle Louise Last Wood		4. DATE OF DEATH Month 4 Day 6 Year 19 57	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 27, 1873
9 AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Massachusetts		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Ranshousen		14 MOTHER'S MAIDEN NAME Harriet Tower	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT Alice Webster, 883 Boulevard, Weehawken, N. J.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Uremia 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-vascular renal disease DUE TO (c) Lidvaned arterio-sclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 wks. 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1957 to 4-6-1957 , that I last saw the deceased alive on 4-5-1957 , and that death occurred at 12:10 A.M. , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Stewart Clapp M.D. 3421 Ingomar St. N.W. Wash 15 D.C.		4-6-57	
PHYSICIAN'S NAME (Type) Stewart Clapp			
22a BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 4/6/57	22c. NAME OF CEMETERY OR CREMATORY Pittsfield Cemetery	22d LOCATION (City, town, or county) (State) Pittsfield, Mass.
23 FUNERAL DIRECTOR'S SIGNATURE J.H. Hines Co 2901 14th N.W.		24a REC'D BY REGISTRAR Rever Thompson	
ADDRESS		DATE 5 1957	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file them with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4200

CERTIFICATE OF DEATH

Reg. Dist. No.

01337
223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tanawana Park, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>		d. STREET ADDRESS <u>103 Woodridge Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Junius</u> Middle <u>Boyd</u> Last <u>Wood</u>		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-27-77</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreign correspondent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>News paper</u>	9. AGE (In years last birthday) <u>79</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Wood</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Boyde</u>	
15. WAS DECEASED IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u> No		16. SOCIAL SECURITY NO. <u>yes</u>	17. INFORMANT <u>Wife</u> Address <u>Same as Deceased</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Several months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>56</u> , to <u>Apr 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Apr 2</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John N. Andrews</u> M.D.		ADDRESS (Street, city or town, state) <u>9601 Coleville Rd</u> DATE SIGNED <u>Apr 2-57</u>	
PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>		<u>Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>4/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Murphy</u>		24. REC'D BY REGISTRAR <u>APR 5-1957</u>	
ADDRESS <u>8434 Galbreath</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 8 1957

RECEIVED

4334
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS Box 319	
3. NAME OF DECEASED (Type or print) First Jackie Middle Lynn Last Wyatt		4. DATE OF DEATH Month April Day 16 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 24, 1956
9. AGE (In years last birthday) 4 yrs		10. IF UNDER 1 YEAR Months 4 Days 23 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jackie Wyatt		14. MOTHER'S MAIDEN NAME Virginia Bolton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute anoxia 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congenital cyanotic heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 MO.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 10 , 19 57 , to April 16 , 19 57 , that I last saw the deceased alive on April 16 , 19 57 , and that death occurred at 4:32 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 4/17/57 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit		22b. DATE THEREOF 4/17/57	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Princeton, W. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR 4-18-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event with a 72-hour delay after death.

9VVVVVVVVVV

RECEIVED

APR 22 1957

BUREAU Y. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4335

CERTIFICATE OF DEATH

Reg. Dist. No.

043324

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>407 HINSDALE LANE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGUERITE E. YANICK</u>		4. DATE OF DEATH Month Day Year <u>Apr 13 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1911</u>
9. AGE (In years lost birth day) <u>45</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Boston Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Dalzell</u>		14. MOTHER'S MAIDEN NAME <u>Margaret K Knode</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Richard J Yanick</u>		Address <u>407 Hinsdale Lane Silver Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis, myocardial infarction</u> DUE TO (c) <u>Heart arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/8</u> , 19 <u>54</u> to <u>9/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/11</u> , 19 <u>57</u> , and that death occurred at <u>8 A. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>J. F. Courtney</u>		M.D. <u>5601-44th St</u>	
PHYSICIAN'S NAME (Type) <u>J. F. COURTNEY M.D.</u>		<u>Washington, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-16-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ford Lenox</u>	22d. LOCATION (City, town, or county) (State) <u>Blodensburg Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home</u>		ADDRESS <u>4812 Ga Ave NW Wash DC</u>	
24a. REC'D BY REGISTRAR <u>APR 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Francis Tatter</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

APR 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04340

CERTIFICATE OF DEATH

Reg. Dist. No.

217

4336

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>Brooke Grove Chronic Hosp -</u>		d. STREET ADDRESS <u>2315 Homestead Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>C</u> Last <u>Gebley</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1866</u>
9. AGE (In years last birthday) <u>90</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Corry, Penna - U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>D. R. Bouee</u>		14. MOTHER'S MAIDEN NAME <u>Lucine Raymond -</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extreme emaciation due to</u> <u>194X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of thyroid with metastasis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>1957</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>9</u> p. m. Month <u>19</u> Day <u>19</u> Year <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 14, 1956</u> to <u>Apr. 22, 1957</u> , that I last saw the deceased alive on <u>Apr. 21, 1957</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Gebley</u> M.D.		DATE SIGNED <u>April 22, 1957</u>	
PHYSICIAN'S NAME (Type) <u>John B. Gebley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>4/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <u>Wilmington, Delaware</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington, D. C.</u>		24a. REC'D BY REGISTRAR <u>APR 24 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Gentle Lawler</u>	

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APR 24 1957

BUREAU V. B.

Dec. 14 1956

John B. Ziegler

D. R. Boone

Personnel

F. White

4/22

6

George

July 23, 1956

20

April 22

Court, Boone - W. B. C.

Boone Academy -

Boone

R.

D.

Brook Grove Church - 2312 Homestead Drive

Home -

Silver Spring

Washington